

HPS Competition

CONTESTANT MEDICAL BRIEFING FORM

Name: _____ Social Security Number: _____

Team Or Affiliation: _____

Person To Contact In Case Of Emergency:

Name: _____ Telephone Number: _____

Family Or Personal Physician:

Name: _____ Telephone Number: _____

MEDICAL INFORMATION:

Any Allergies: Yes _____ No _____

If Yes, What: _____

Any Permanent Disabilities: Yes _____ No _____

If Yes, What: _____

Taking Any Prescription Medication: Yes _____ No _____

If Yes, What: _____

Any Known Heart/Circulatory Problems: Yes _____ No _____

If Yes, What: _____

Do You Have Any Pulmonary Problems: Yes _____ No _____

If Yes, What: _____

Do You Have Diabetes Or Seizures: Yes _____ No _____

If Yes, What: _____

Any Other Medical Detail Which The EMT Or Physician Should Know About You:

Date Of Last Physical: _____

Signature: _____ Date: _____

If a contestant has not reached 18 years old by July 28, 2004, a parent must countersign below:

Parent Signature: _____ Date: _____