MEDICAL INFORMATION FORM
FOR PARTICIPANT IN THE
V-Force SFC Certification Course 2009

All participants must read, complete and sign this form. Please list all information requested. **Please print.**

SECTION I – PERSONAL INFORMATION

TEAM NAME: ______________________________ NUMBER: ________

NAME: ________________________ ________________________ ______
LAST FIRST M.I.

____
STREET

____
CITY, STATE or PROVENCE, COUNTRY

____
PHONE NUMBER

DOB: ______ SEX: M __ F __

HT: _________ WT: ________

EMERGENCY CONTACT

NAME: __________________________

PHONE: _________________________

RELATIONSHIP: ____________

SECTION II – MEDICAL HISTORY

Are you currently taking any type of prescription or over the counter medication?
YES ___ NO ___
If "YES", please list names and dosages.

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Are you allergic to any type of **medication**?
YES ___ NO ___
If "YES", please list. ______________________________

____

Do you currently have or have had a history of any of the following?

	YES	NO		YES	NO		YES	NO
Allergies (food, dust, etc.)			Dizzy/Fainting			Joint Problems		
Allergies (insect bite)			Epilepsy			Kidney Problems		
Arthritis			Eye Problems			Major Surgery (within 3 yrs)		
Asthma			Cold Injuries			Malaria		
Back Problems			Headaches			Mononucleosis		
Blood in Stool			Hearing Problems			Nausea / Vomiting		
Blood in Urine			Heart Problems			Numbness in Limbs		
Blurred Vision			Hepatitis (what type)			Respiratory Problems		
Bronchitis			Hernia			Stomach Problems		
Cancer			High/Low Blood Pressure			Tuberculosis		
Diabetes			Hyper/Hypothyroidism			Other not Listed		

If "YES" to any of the above, please explain. ____

____

What is your Blood Type / RH Factor? ________________________________

Do you wear eyeglasses/contact lenses? YES ___ NO ___ If "YES", do you have spare glasses / contacts or a copy of your prescription? YES ___ NO ___	Females - Are you, or could you be pregnant? YES ___ NO ___ If "YES", when is your "due date"? ________________ When was your last menstrual period? _____________

SECTION III – HEALTH CARE PROVIDER AND INSURANCE INFORMATION

NAME: ____ PHONE NUMBER: ________________________________

ADDRESS: ____

____

INSURANCE CARRIER: ____

POLICY NUMBER: __________________________________ GROUP NUMBER: ____________________________

Please attach a copy of your insurance card to the back of this form.

To be used in the event of hospitalization.

I, ____, verify that the above information is true and correct, to the best of my knowledge. I understand that **V-Force Scientific Fighting Concepts** will uphold patient confidentiality and safeguard my medical and personal information. I understand that I have the right to refuse medical treatment, except where the law allows for Implied Consent Treatment. I understand **that V-Force Scientific Fighting Concepts** provides this medical care to me with no direct fee. I understand that the medical personnel will make medical treatment and transport decisions that are based solely on what is in my best medical interest.

Signed: ____ Date: ______________________

OFFICE USE ONLY BELOW THIS LINE

MEDICAL REVIEW AND NOTES

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EVENT: ____ DATES: ___________________________

REVIEWED BY: ____ DATE: ________________