ROANOKE COLLEGE COMMUNITY PROGRAMS
MEDICAL INFORMATION FORM

The information you provide may assist people in aiding you in case of an emergency.

_____ _____
Program/Conference/Camp Name Program Dates

First Name_____ M.I.:_____ Last Name _____

Home Address

_____
City State Zip Code

Age _____ Birth Date _____ Circle one: Male / Female

Blood Type _____ Date of last tetanus shot _____ Do you wear glasses or contact lenses? _____

Emergency Contact #1 _____ Relationship_____

Home Telephone # _____ Work # _____ Cell # _____

Emergency Contact #2 _____ Relationship_____

Home Telephone # _____ Work # _____ Cell # _____

Describe treatments you are receiving for a current illness/conditions (incl. chronic illnesses i.e. asthma, diabetes, seizures)

_____

_____

List any allergies (e.g.: insect stings, food, medication, etc.)_____

_____

List any medications you are currently taking_____

_____

PERMISSION TO TREAT

I give permission for 1) Roanoke College employees to administer first-aid to me in the event that I am unconscious or otherwise unable to give consent; 2) medical personnel to treat me in the event that I am unconscious or otherwise unable to give consent.

_____ _____ _____
(printed name) (signature) (Date)

_____ _____ _____
(printed name of Guardian if participant under 18 years old) (Signature) (Date)