Medical Information

Name _____ Work Phone _____
Address_____ Home Phone _____
_____ Fax_____
Date of last physical _____ E-mail _____

1. List any physical disabilities or health problems you have, and indicate whether you have special needs regarding sleeping accommodations, meals, etc.

2. List all medications you take on a regular basis, with exact dosages.

3. List any allergies.

4. Ask your physician to read and sign the accompanying sheet.