# Okaloosa County ARES Group
# Member Medical Form

Please complete this form and carry it in your radio gear pack in a sealed plastic bag.
This information will be used only in the event that you require medical attention.

***GENERAL INFORMATION***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** | | | | | | | |
| **Address** | | | | | | | |
| **City, State, Zip code** | | | | | | | |
| **Telephone(s)** | | | | | | | |
| **Email Address** | | | | | | | |
| **Birthdate** | | | **Gender (M/F)** | | **Blood Type** | | |
| **Height** | | **Weight (lbs)** | | **Blood pressure** | | **Resting pulse** | |

***EMERGENCY CONTACT(S)***

| | | | |
|---|---|---|---|
| **Primary's Name** | | **Relationship** | |
| **Address** | | | |
| **City, State, Zip code** | | | |
| **Telephone(s)** | | | |
| **Secondary's Name** | | **Relationship** | |
| **Address** | | | |
| **City, State, Zip code** | | | |
| **Telephone(s)** | | | |

***MEDICAL INSURANCE INFORMATION***

| | | | |
|---|---|---|---|
| **Company name** | | **Policy number** | |
| **Contact phone number** | | | |

***ALLLERGIES (Include medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.))***

| **Allergy** | **Reaction** | **Medication Required, if any** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |



Rev 2011-03-14

*MEDICATIONS*

| Name | Dosage | Frequency | Side Effects (known & potential) | Reason for Taking |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

**MEDICAL HISTORY**

- **Accidents, operations, hospitalizations in last 3 years?**
- **History of heart problems? (Yes, No)**
  **If yes, please explain.**
- **History of high blood pressure? (Yes, No)**
  **If yes, please include medications above.**
- **Asthma ? (Yes, No)**
  **If yes, please include medications above.**
- **Diabetes? (Yes, No)**
  **If yes, please include medications above.**
- **Problems with your eyes or vision? (Yes, No)**
  **If yes, please explain briefly**
- **Problems with your hearing? (Yes, No)**
  **If yes, please explain briefly**
- **Any bone, joint, or muscle problems? (Yes, No)**
  **If yes, please explain briefly**
- **History of seizure(s)? (Yes, No)**
  **If yes, please explain briefly**
- **Ever experienced altitude problems? (Yes, No)**
  **If yes, please explain briefly**
- **Any other medical issues that might affect your performance? (Yes, No)**
  **If yes, please explain.**

- **. Please state below all physical or mental limitations and restrictions of which you are aware:**

| |
|---|
| |

*PHYSICIAN*

| Physician's name(s)<br>1.<br>2. | Specialty | Phone number |
|---|---|---|
| Address | Date of last<br>physical exam | |