



MEDICAL INFORMATION

P E R S O N A L I N F O R M A T I O N

Name _____ Address _____

City _____ State _____ Zip _____ Telephone (____) _____
(please circle one)

Age _____ Birthdate _____ Gender _____ T-Shirt Size Adult or Child S M L XL XXL

In Case of Emergency: Parent/Guardian Names _____ Telephone (____) _____

Address _____ City _____ State _____ Zip _____

Alternate Emergency Telephone (____) _____ Name _____

Duration Of Internship: From ____/____/____ to ____/____/____

M E D I C A L I N F O R M A T I O N

Check the box if you have ever had any of the following apply to you. If necessary, please indicate the number and explain below.

- | | |
|---|---|
| <input type="checkbox"/> 1. Allergies
<input type="checkbox"/> 2. Asthma
<input type="checkbox"/> 3. Bee/Wasp Reaction
<input type="checkbox"/> 4. Diabetes
<input type="checkbox"/> 5. Dizziness or fainting
<input type="checkbox"/> 6. Epilepsy
<input type="checkbox"/> 7. Hay Fever
<input type="checkbox"/> 8. Heart Trouble | <input type="checkbox"/> 9. High Blood Pressure
<input type="checkbox"/> 10. Operation in last year
<input type="checkbox"/> 11. Penicillin Allergy
<input type="checkbox"/> 12. Pregnant
<input type="checkbox"/> 13. Physical Handicap
<input type="checkbox"/> 14. Regular Medication
<input type="checkbox"/> 15. Respiratory Problems
<input type="checkbox"/> 16. Other (please explain) |
|---|---|

Comments _____

Insurance Carrier _____ Policy # _____ Date of last Tetanus Shot _____

I have answered each question on this form to the best of my knowledge,

Intern Signature _____