

HPS Competition

CONTESTANT MEDICAL BRIEFING FORM

Name: _____ Social Security Number: _____

Team Or Affiliation: _____

Person to contact in case of emergency:

Name: _____ Telephone Number: _____

Family Or Personal Physician:

Name: _____ Telephone Number: _____

MEDICAL INFORMATION:

Any Allergies: Yes _____ No _____ If Yes,

What: _____

Any Permanent Disabilities: Yes _____ No _____

If Yes, What: _____

Taking Any Prescription Medication: Yes _____ No _____

If Yes, What: _____

Any Known Heart/Circulatory Problems: Yes _____ No _____

If Yes, What: _____

Do you have any pulmonary problems: Yes _____ No _____

If Yes, What: _____

Do you have diabetes or seizures: Yes _____ No _____

If Yes, What: _____

Any other medical detail which the EMT or physician should know about you:

Date Of Last Physical: _____

Signature: _____ Date: _____