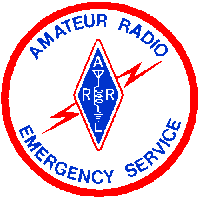
**Santa Fe ARES   
Member Medical Form**



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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Side 1***MEDICATIONS***

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

**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) 1.**  **2.** | **Specialty** | **Phone number** |
| **Address** | **Date of last  physical exam** | |

Side 2