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