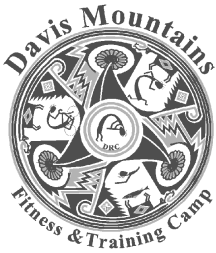


Medical Information



Name: _____ Age: _____

Current Medical Issues: _____

Other Health Concerns/Risks: _____

Current Prescribed and Other Medications/Supplements: _____

Allergies: Medications: _____

Insects: _____

Plants: _____

Past/Current Medical/Surgical Treatments: _____

Primary Doctor

Name: _____

Telephone Number: _____

City/State: _____

Medical/Health/Health Risk Topics of Interest to You (for possible discussion):

Staff Initial _____

Form date: January 20, 2008