Health and Medical Background

Name:_ Age:_

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work phone:_____

Does the individual listed above have any health problem or limiting physical disabilities or handicaps (temporary or permanent) that may affect their ability to participate in the program being offered by Project Imo, Inc.? Yes □ No □
If yes, please explain:_____

_____

Does the individual have any allergies? Yes □ No □
Reactions to medications? Yes □ No □ Any medical limitations? Yes □ No □

If yes to any part of this question, please explain _____

_____

Is the individual currently taking any medications? Yes □ No □
Is yes, please list what medication is being taken and what condition it is for:_____

_____

HEALTH/MEDICAL INSURANCE IS MANDATORY.

Health/Medical Insurance Carrier:_____

Policy Number:_____

Please provide the following information in case of emergency:

Person to notify _____

Relationship: _____Phone:_____

Medical Training and Experience:

Please list any formal first aid/ CPR/medical training you have

Training *Provider* *Certification Dates/#*

_____

_____