Blue Shadows Mounted Drill Team

Medical Information Sheet

Member	Last Name	First	D.O.B.	Troop

Parent Name	Phone # Home	Phone # Cell
Address	**City**	**Zip**
Parent Name	**Phone # Home**	**Phone # Cell**
Address	**City**	**Zip**
Nearest Relative	**Phone # Home**	**Phone # Cell**
Address	**City**	**Zip**
Other Emergency Contact Name	**Phone # Home**	**Phone # Cell**

Does your son/daughter/member have any special health problems? Please comment.

Allergies____

Asthma____

Convulsions / Epilepsy____

Diabetes____

Chronic Flu / Cold____

Fainting____

Heart Trouble____

Insect Sting/ Plant Poisoning____

Recent Surgeries____

Serious Injury / Illness____

Other____

Comments____

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Are Immunizations up to date? ____

Date of last Tetanus___________

Is child under any special medication? Please Specify_____________________________________

Is child allergic to any medication? Please Specify____

Any restricted activities? Please Specify____