

Franklin Park Speed Skating Club

Personal Medical History

(complete one form for each member of your family)

Name: _____ Date of Birth: _____

Address: _____

Contact Person (name/relationship): _____

Telephone/Cell #'s: _____

Physician Name/Phone #: _____

Dentist/Orthodontist Name(s)/#'s: _____

Eye Dr. Name/Phone #: _____

Other(s) Doctor Name/Phone # (if any): _____

Current Medical Condition(s): _____

Prescription and non-prescription medications taken: _____

Drug sensitivity and allergies (describe): _____

Date of last Physical Exam: _____

Date of last Tetanus Shot: _____

List any other relevant medical information: _____
