



2009 Adult MEDICAL INFORMATION

Last Name: _____ **First Name:** _____

Address: _____

Date of Birth: _____

Give all information needed to provide as safe and as full participation as possible and explain any YES answers below:

In the event of an emergency, notify:

Name: _____

Relationship: _____

Contact Phone No(s): _____ (Home)
_____ (Work)
_____ (Cell)

Primary Care Physician: _____
Phone: _____

Primary Dentist: _____
Phone: _____

Health Insurance Provider: _____
Policy Number: _____

Medical Information: Give all information needed to provide as safe and as full participation as possible and explain any YES answers below:

Asthma	Yes () No ()	Heart Disease	Yes () No ()
Allergies	Yes () No ()	High Blood Pressure	Yes () No ()
Convulsions	Yes () No ()	Diabetes	Yes () No ()
Other	Yes () No ()		

If yes, please explain:

Does participant take any prescription drugs regularly? Yes () No ()

If yes, please explain:

Statement of Medical Conditions and Consent for Medical Treatment

I attest that I am in good health and that there is no medical condition that precludes my involvement in the programs of Lincoln Maritime Center, Inc. ("Lincoln"). I grant permission to Lincoln and its employees to administer medical treatment and to secure medical treatment for me in the event of injury or sickness from whatever cause.

Signature of Participant

Date