



**ROANOKE COLLEGE COMMUNITY PROGRAMS
MEDICAL INFORMATION FORM**

The information you provide may assist people in aiding you in case of an emergency.

Metro Washington DC Synod, ELCA
Program/Conference/Camp Name

June 12 – 14, 2008
Program Dates

First Name _____ M.I.: _____ Last Name _____

Home Address _____
City State Zip Code

Age _____ Birth Date _____ Circle one: Male / Female

Blood Type _____ Date of last tetanus shot _____ Do you wear glasses or contact lenses? _____

Emergency Contact #1 _____ Relationship _____

Home Telephone # _____ Work # _____ Cell # _____

Emergency Contact #2 _____ Relationship _____

Home Telephone # _____ Work # _____ Cell # _____

Describe treatments you are receiving for a current illness/conditions (incl. chronic illnesses i.e. asthma, diabetes, seizures)

List any allergies (e.g.: insect stings, food, medication, etc.) _____

List any medications you are currently taking _____

PERMISSION TO TREAT

I give permission for 1) Roanoke College employees to administer first-aid to me in the event that I am unconscious or otherwise unable to give consent; 2) medical personnel to treat me in the event that I am unconscious or otherwise unable to give consent.

(printed name)

(signature)

(Date)

(printed name of Guardian if
participant under 18 years old)

(Signature)

(Date)