



# MEDICAL CONDITIONS

CHECK ALL THAT APPLY

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> NO MEDICAL CONDITIONS | <input type="checkbox"/> STROKE            | <input type="checkbox"/> SEIZURE DISORDER           |
| <input type="checkbox"/> ASTHMA                | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> DIABETES/INSULIN DEPENDENT |
| <input type="checkbox"/> HEART PROBLEMS        | <input type="checkbox"/> HYPERTENSION      | <input type="checkbox"/> _____                      |
| <input type="checkbox"/> _____                 | <input type="checkbox"/> _____             | <input type="checkbox"/> _____                      |
| <input type="checkbox"/> _____                 | <input type="checkbox"/> _____             | <input type="checkbox"/> _____                      |
| <input type="checkbox"/> _____                 | <input type="checkbox"/> _____             | <input type="checkbox"/> _____                      |

## ALLERGIES

- |   |                                |                                |
|---|--------------------------------|--------------------------------|
| <input type="checkbox"/> NO KNOWN ALLERGIES | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____              | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____              | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____              | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Please list any other information the Emergency Responders should know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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| <input type="checkbox"/> _____              | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____              | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

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