

MEDICAL INFORMATION FORM

This form is intended to gather **voluntary** medical information for members of Realms of History to aid mundane emergency medical personnel if a need arises.

Mundane Name: _____

Personna Name: _____

Name for Emergency Contact: _____

Phone Number for Emergency Contact: _____

Known Allergies: _____

Current Medications: _____

Circle any medical history that applies:

Hypertension

Heart Disease

Diabetes

Asthma

Seizures

Contacts

Excessive Bleeding or clotting problems

Any additional information (specifically if you have circled any of the above).

State: _____

I, the undersigned, do acknowledge that the information I have given on this forms is purely voluntary and that I have authority to issue it.

Signature

Date