

Local Pageant Medical Form

Name _____ Age _____

Email _____ Cell number _____

Mother's Name _____ Cell number _____

Father's Name _____ Cell Number _____

What medicines are you taking? _____

Known allergies: _____

Do you have any on-going chronic condition(s)? _____

Have you had seizures in the past? _____

Do you take insulin? _____

Do you carry an Epi pen? _____ Where is it located today? _____

Do you use an inhaler? _____