SRCRC HIGH ALTITUDE TRAINING CAMP
MEDICAL INFORMATION

NAME:_____

DATE OF BIRTH:_____

CURRENT MEDICAL ISSUES:_____

_____

OTHER HEALTH CONCERNS/RISKS:_____

_____

CURRENT PRESCRIBED AND OTHER MEDICATIONS/SUPPLEMENTS:_____

_____

ALLERGIES:

Medications:_____
Plants:_____
Foods:_____

PAST/CURRENT/SURGICAL TREATMENTS:_____

_____

PRIMARY DOCTOR

Name:_____
Telephone Number:_____
City, State:_____

DIETARY RESTRICTIONS:

Vegetarian_____ Vegan_____ _ Gluten-Free_____ Other_____