Special Olympics Mississippi

SUPPLIMENTAL MEDICAL INFORMATION FORM

Name: _____ Sport: ——————— Gender:

Date of Birth: _____ Team Name: ——————————

Parent/Guardian Name: _____ Contact Person's Phone:_____

Bring medications in the original prescription bottles in a ziplock bag with athlete's name on bag.

Medication Name	Dosage	Frequency	Specific times of day the medication is taken	Prescribed for What Condition?

1. Are any of your medications new within the last 6 months? 0 yes 0 no

   If yes, which one(s)? ——————————————————————

2. Do you have a history of seizures or epilepsy? 0 yes 0 no
   If yes, what type, frequency, date of last seizure and potential triggers?----------

   _____

3. Do you have any allergies to medications, foods or insects? 0 yes 0 no

   If yes, please list those specific allergies: ——————————————————

Primary Physician's name and phone number: ——————————————————

Form Completed by:_____ Relationship to Athlete:_____

Today's date: ————————