MINLAK TRAINING PROGRAMS INC.
Medical Statement & Contact Form

Date:______________________________

Name:________________________ Date of Birth________________________

Mailing Address (please include postal code):______________________________________

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Parent/Guardian____

Telephone (H) _________________(C) _________________(W)_________________

Medicare No._________________________

Name of Doctor________________________ Telephone No.______________________

PERSON TO CALL IN CASE OF EMERGENCY DURING WORK HOURS:

(1) Name: ____________________________ Telephone: ____________________

(2) Name: ____________________________ Telephone: ____________________

Any special medical conditions (ex: diabetes, epileptic seizures, heart disorders, allergies, etc.)

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DATE OF LAST TETANUS SHOT __________________________

MEDICATIONS:
(1) NAME OF MEDICATION: ________________________DOSAGE:______________
CONDITION BEING TREATED: ____

(2) NAME OF MEDICATION: ________________________DOSAGE:______________
CONDITION BEING TREATED: ____

Are there any side affects to medication(s) being taken? YES ( ) NO ( )
COMMENT: (side affects that may occur):____________________________________

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SIGNATURE OF PARENT/GUARDIAN____
DATE:____________________