Applicant's Name: _____ CSB: _____ Date: _____

CURRENT MEDICAL CONDITION

Current Family Physician's Name: _____

Address: _____ Telephone #: ( ) _____

Current Specialist Physician's Name: _____

Address: _____ Telephone #: ( ) _____

Current Dentist's Name: _____

Address: _____ Telephone #: ( ) _____

Current Medications (include both prescription and over-the-counter drugs)

Drug Name	Date Prescribed	Dosage	Times Given	Reason

Describe All Medical Conditions Currently Being Treated.

CURRENT MEDICAL CONDITION . . . CONTINUED

List All Stimuli To Which The Applicant Has An Allergic Reaction:

	Type of Reaction
Drugs:	
Foods:	
Other:	

Is the applicant on a special diet? ( )Yes ( ) No If Yes, describe the diet, the reason for it and give the name of the physician prescribing the diet.

If the applicant has seizures, describe them by indicating the type, the frequency and the length of the average seizure. Also note any unusual or remarkable conditions associated with the seizure disorder. Are the seizures considered to be under control?

Check All Items, Which Apply To The Applicant.

		Paralysis
___ Hears Well	___ Sees Well	___ One Arm
___ Hard of Hearing	___ Difficulty Seeing	___ One Leg
___ Deaf	___ Blind	___ Both Arms
___ Unknown	___ Unknown	___ Both Legs

Does the applicant require any special equipment such as glasses, hearing aids, helmet, wheelchair, braces, or walker? If so, describe the item and the applicant's capability to use it independently.