Date: ________\ 20____

Last Initial: ____________

Stanford Alpine Club Medical Information Form

Personal Information

Name:		
Date of Birth:		Gender:
Address:		
Phones:	H:	e-mail:
	W:	
	cell:	

Insurance

Company Name:	phone number:
Policy/ ID number:	

Emergency Contact

Name:	Relation:
Phone:	e-mail:

Medical History

Allergies? (if none, put none)
Previous injury or illness
Are you on any Medications? Please list

Do you consent to Medical Treatment? Please initial: __________ Yes __________ No