
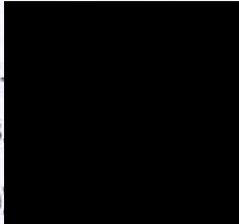
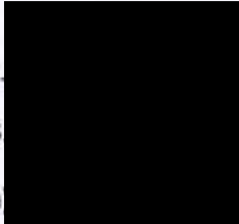


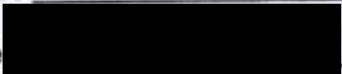
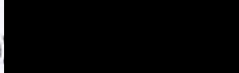
Appendix B

## MEDICAL FORM

This form should be carried on your person and on file with your commander.  
Form should be updated as needed.

Name  Age 

Address \_\_\_\_\_ D.O.B. 

Phone  Blood Type (if known) 

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Next of Kin \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance No. \_\_\_\_\_

Allergies (list all – i.e. to medicine, food, plants or animals): \_\_\_\_\_  
