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 John Doe _____ Age 35 _____

Address 12 Elm St, Springfield _____ D.O.B. _____

Phone 555-1234 _____ Blood Type (if known)____ Sex M

Doctor's Name _____ Phone _____

Next of Kin 1990-01-01 _____ Phone _____ Relation _____

Insurance Company _____ Insurance No. _____

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

_____

Health problems (list all – i.e. heart, respiratory, blood pressure, asthma, diabetes, etc…):