RV RC Real Voices Real Choices

Building a Better Tomorrow.

Medical Information Form

The completion of this form is optional; however, please note that in the case of a medical emergency **this information would be critical** to ensure that you receive the most appropriate medical care.

Attendee First Name _____ **Last Name** _____

Age _____

Name of Emergency Contact _____

Emergency Contact Phone Number _____

Alt. Phone Number _____

Allergy Questions

Do you have any allergies? ◯ **Yes** ◯ **No**

Medication Allergies?	
Food Allergies?	
Other Allergies?	

General Health Questions

Do you have any ongoing medical conditions? ◯ **Yes** ◯ **No**

Please specify below and check all that apply.

◯ **Asthma** ◯ **Diabetes** ◯ **Seizures** ◯ **Heart Condition**

◯ **High Blood Pressure**

Other medical condition? _____

Have you been hospitalized in the last year? ◯ **Yes** ◯ **No**

If yes, for what? _____

Do you wear glasses of contacts? ◯ **Yes** ◯ **No**

Do you wear hearing aids? ◯ **Yes** ◯ **No**

Please describe the assistive devices you use (i.e. wheelchair, toilet riser, grab bars, etc.):

_____

_____

Current Medications

Medication Name	Dose	How Often

To complete this form online, visit this link.

Otherwise, please send the completed form to:

Missouri Mental Health Foundation
221 Metro Drive, Suite C
Jefferson City, MO 65109

Or email send via email to:
ConsumerConference@dmh.mo.gov

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