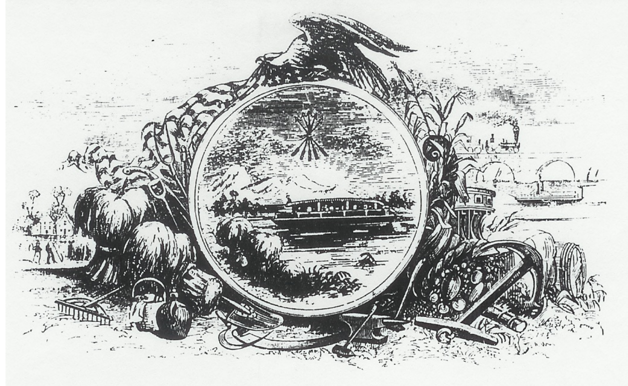

Surgeon's Certificate
Medical Department, Ohio State Militia

Name: ____

Emergency Contact: ____

Primary Contact No.: (   ) ________________________ Relationship: __________________

Secondary Contact No: (   ) ________________________

Secondary Emergency Contact: ____

Primary Contact No.: (   ) ________________________ Relationship: __________________

Secondary Contact No.: (   ) ________________________

The following information is completely voluntary. However, because of the possibility of injury or other medical crisis during an event, this information can be to your benefit.

Do you suffer from any of the following: (check if yes)
___ Asthma ___ Diabetes ___ Fainting Spells ___ Heart Trouble ___ Convulsions

Allergies: ____

to medications: ____

Other conditions: ____

Medications taken: ____

Further explanation (if needed): ____

____

Immunizations/dates:

___ Tetanus ___/___/___ Others: ____

____ ___/___/___
(signature) (date)