

DYNA Inc. Summer Chill Medical Information Form

DYNA Member's Full Name: _____

Parent/Guardian's Full Name(s): _____

Address: _____

Home Phone Number: _____ Date of Birth: _____

Parent/Guardian Name(s) and Cell Phone Number(s): _____

General Physician Name and Office Phone Number: _____

Dysautonomia Physician Name and Phone Number: _____

Dysautonomia Condition (only dysautonomia condition) _____

Other pertinent medical information (list only what applies in case of emergency medical treatment):

Allergies (list only those that apply in case of emergency medical treatment) _____

Current Medications:

Please read and sign the following and return with your registration and a copy of your health insurance card.

In case of a medical emergency, when parent or legal guardian can not be reached, I hereby give my permission to DYNA, Inc. to secure treatment for my child.

Signature: _____ Date: _____

Relationship to child: _____