

## MEDICAL INFORMATION SHEET

Please answer each and every question carefully and honestly.

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you take any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list all medications and dosages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you wear glasses or contacts? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you on a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you subject to headaches? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use the bathroom frequently? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, to what?

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Are you afraid of small spaces? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you tend to be hot or cold natured? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have **any** medical problems that should be noted in your records for the SPACE Shuttle Program?

I have read and assisted my child in filling out this medical form. To the best of my knowledge, the information is both current and accurate.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**