

State Form

MISS OHIO HIGH SCHOOL AMERICA PAGEANT

Medical Information Form | Form C

State Title: _____

Contestant's Name: _____

Date of Birth: _____

Home Address: _____

Who should be called in case of an Emergency?

Name: _____

Address: _____

Phone Number: _____ Other: _____

Medical Insurance Co / HMO Name: _____

Employer or Company Name (If Group Plan): _____

Policy Number: _____

Name of Subscriber: _____

Subscriber's Address: _____

Relationship of Subscriber to Contestant: _____



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Family Physician and Phone Number: _____

Contestants Blood Type: _____

Are you allergic to anything that causes an allergic reaction when taken or come in contact with?

List any physical problems that could cause you discomfort: _____

Dental Insurance Company Name: _____

Address: _____

Employer or Company Plan (if Group Plan): _____

Policy Number: _____

Name of Subscriber: _____

Subscriber's Address: _____

Relationship of Subscriber to Contestant: _____

