COBB COUNTY SHERIFF'S OFFICE

SENIOR VOLUNTEER PROGRAM

MEDICAL INFORMATION

NAME:		DATE:			
ADDRESS:					
HOME PHONE:		PHYSICIAN:		BLOOD TYPE:	
DO YOU HAVE HEART TROUBLE? IF YES, PLEASE EXPLAIN,	YES___ NO___				
DO YOU HAVE HIGH BLOOD PRESSURE?	YES___ NO___	ARE YOU DIABETIC?	YES___ NO___		
PRESENT SICKNESS/DISABILITIES:					
PREVIOUS SURGERIES/DATES:					
ARE YOU ON ANY MEDICATION?	YES___ NO___	IF YES, PLEASE LIST.			
IS MEDICATION PRESCRIBED BY A PHYSICIAN?	YES___ NO___	HOSPITAL PREFERENCE (NAME AND ADDRESS):			
INSURANCE COMPANY:		GROUP NUMBER:		POLICY NUMBER:	
DO YOU HAVE A MEDICAL PROBLEM WE SHOULD BE AWARE OF WHILE YOU ARE WORKING WITH THE COBB COUNTY SHERIFF'S OFFICE THAT YOU HAVE NOT MENTIONED?					
IN CASE OF EMERGENCY NOTIFY:				RELATIONSHIP:	
ADDRESS:					
CITY :		STATE:		PHONE:	

FORM CCSO-006