HEALTH AND MEDICAL INFORMATION

Name ____

Family Physician _____________________________________Phone _____________________________

Medical Plan ____Plan# ____________________________

*Do you authorize medical treatment for yourself in an emergency, as considered necessary by the attending physician?
_____Yes _____No

Please attach a copy of your insurance card (front and back).

State any reasons why you do not want medical care given to you in an emergency: ____________________________

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List your allergies: ____

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List all conditions (such as allergies, seizures, asthma, diabetes) for which you require ongoing medication and state the type and frequency of medication taken: ____

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List all food allergies:

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Health and Medical Inforamtion con't

In case of emergency, contact: ____

Home or Work Phone___________________________________**Cell Phone**_____________________________________

Signature of Participant____**Date** ___________________

____

Additional allergies

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Additional food allergies

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