Name_____

Address_____City_____State_____

Email address_____ Phone #_____

PERSONS TO CONTACT IN THE EVENT OF AN EMERGENCY

This medical information may be necessary in the event of serious illness or accident. Please complete this form accurately. The facts you disclose will be kept confidential and the information provided will be given to others only in an emergency.

This will only be shared with the medical staff in case of emergency.

Name _____
Relationship _____
Address_____
City _____
State_____ Zip Code_____
Cell Phone _____
Work Phone _____

Name _____
Relationship _____
Address_____
City _____
State_____ Zip Code_____
Cell Phone _____
Work Phone _____

☐ I decline and/or prefer not to include my medical information on this form. I understand by not completing the form, I give up all rights to claims or cause of action of any kind arising out of my decision.

Signature_____ Date _____

Current Care:
If you are currently under the care of a medical professional (physician, counselor, psychiatrist, psychologist please list your medications with you and will only be shared in the event of an emergency.

Physician_____Phone #_____
Health Insurance Company _____

Medical conditions e.g., diabetes, high blood pressure, etc.		Allergies: peanuts, fish, etc.

CURRENT MEDICATIONS I AM TAKING Important: Please spell these CORRECTLY	DOSAGE (mgs.)	FREQUENCY (mgs.)	COMMENTS