



# Emergency Medical Form

THIS INFORMATION WILL BE KEPT CONFIDENTIAL

## Basic Information

Name (as printed in program)

Role

Date of Birth

Address (Current)

Address (Permanent)

Cell Phone #

Home Phone #

Other #

## Emergency Contacts

Name

Relationship

Cell Phone #

Home/Other #

Name

Relationship

Cell Phone #

Home/Other #

## Medications, Allergies, & Conditions

Do you have any of the following allergies?

- Laundry detergents    Stings/Bites    Latex    Cigarette Smoke    Fabrics    Medications  
 Perfumes/Scents    Liquids    Foods    Other

If you checked any boxes, please explain severity and treatment below:

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

Current medications, including dosage:

\_\_\_\_\_

Current Medical Conditions (please be thorough):

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

## Signature

Signature

Date