

Medical & Emergency Information

CONFIDENTIAL

Name: _____ Date: ____/____/____
Last First Middle Initial

Birth date: _____ Age: ____ Male: ____ Female: ____ Blood Type: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Emergency Contact:

1: _____
Name phone Relationship

2: _____
Name phone Relationship

Insurance:

Company: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Policy Number: _____

Personal Medical Information/History:

List all prescription and non- prescription medications that you are taking: _____

List all Drug sensitivity and allergies (describe): _____

Do you currently have any medical problems (describe)? _____

Do you have a current tetanus immunization (within last 10 years) Yes ___ No ___

Have you ever been told you had one of the following?

Lung Disorder	Yes ___ No ___	High Blood Pressure	Yes ___ No ___
Heart Trouble	Yes ___ No ___	Musculoskeletal Disorders	Yes ___ No ___
Nervous Disorder	Yes ___ No ___	Diabetes	Yes ___ No ___
Seizures	Yes ___ No ___	Hepatitis	Yes ___ No ___
Malaria	Yes ___ No ___	Asthma	Yes ___ No ___
Hearing or vision problems	Yes ___ No ___		

I hereby certify that the above information is a true and correct statement of my medical information.

Signed: _____ Print name: _____ Date: _____

Medical or Surgical Procedure Consent

In the case of emergency wherein I am incapable of giving consent due to illness or injury, I hereby authorize any qualified person to administer first aid and/or other necessary treatment. Further I authorize and license surgeon to perform surgery, if need for surgery is agreed upon by a qualified physician.

Signed: _____ Print name: _____ Date: _____