

**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: \_\_\_\_\_