MEDICAL FORM

There is a good chance this form will not be used, but we think we should have this information available in case it is needed.

We will seal the information in an envelope, to be opened only in case of necessity.

Please complete A SEPARATE FORM FOR EACH PERSON IN YOUR GROUP.

Full name_____

Address_____

Birth date_____ Social Security Number _____

Emergency contact_____

Contact telephone: home_____work_____cell_____

Primary health insurance: company_____number_____

Secondary health insurance: company_____number_____

PLEASE INCLUDE A PHOTOCOPY OF INSURANCE CARDS.

Known medical conditions_____

_____

_____

_____

Medications currently being taken_____

_____

_____

Drugs to which you have an adverse reaction:_____

_____

I hereby certify that the above information is correct:

Signature:_____ Date_____