Medical Information and Emergency Contact Form

Name: ____
Address: ____
City/state/zip: ____
Phone number: ____
Date of Birth: ____

Emergency Contact #1

Name: ____________________________
Relationship: _______________________
Address: ___________________________
City/state/zip: ______________________
Phone number: _____________________

Emergency Contact #2

Name: ____________________________
Relationship: _______________________
Address: ___________________________
City/state/zip: ______________________
Phone number: _____________________

Please circle all your known medical conditions and explain in the area provided below:

Hypertension / Diabetes / Heart Disease / Respiratory Disorders /
Blood Disorders / Arthritis / Kidney Disorders / Orthopedic Concerns
Seizures / Other - Specify: ____
Have you ever experienced a Heat or Cold Related Emergency in the Past: Y or N
If you answered yes to any of the above please explain below!
Explanation: ____
____
____
____

Please list all **medications** presently taking. Identify name, dosage needed and frequency.
____
____
____

Please list all known **allergies**, including medications, bee stings, food, etc.
____
____

Please list any other pertinent information:_____________________________________
____
____
Name of family physician: ______________________Phone number: ________
Your Signature: _____________________________ Date:_____________