Southmoreland Band

ADULT MEDICAL INFORMATION

Information Updated _____

_____ Date _____

Last name *First name* *Middle name*

Date of Birth: _____ **Age:** _____ **Gender** _____

Month/Day/Year

Present Address: _____

Street

_____

City, State, and Zip Code

Telephone Number: **Home** ___-_____-_____
Cell ___-_____-_____
Work ___-_____-_____

Emergency Contact Person:

Name: _____ **Relationship**_____
Phone Number(s) _____ _____

Name: _____ **Relationship**_____
Phone Number(s) _____ _____

Physician: _____
Telephone number: _____

Are you currently taking any prescribed medications? _____**Yes** _____**No**
If yes, give the name of the medication and the doctor's name and phone number:

_____

_____

List any medical problems not included above that the medical personnel should be made aware (example: allergies, diabetes, seizures, asthma, heart condition, recent surgeries, etc.):

_____

_____

_____

Date of last tetanus shot: _____

Other concerns: _____

_____

Insurance Information:

Name of insurance provider: _____

ID number: _____

I certify that the information provided is correct to the best of my knowledge. All information is for emergency use only and will remain strictly confidential. If at any time the above information must be changed, I will notify the director/nurse that my information must be updated.

_____

Print name ***Date***

_____

Signature