

2023 EMERGENCY HEALTH INFORMATION

Name _____ Cell Phone (____) _____

Address _____

Did you come with someone else? _____ If yes, their name: _____

In case of emergency, contact:

Name _____ Phone (____) _____

Address _____

Medications you are taking: _____

If you have medication to be taken in an emergency, where is it kept? _____

Do you have allergies? _____ If yes, please specify the allergy and the reaction you get. _____

Is there any other medical information we should know about you? _____

Insurance Company's Name: _____

Member ID# _____ Carrier's Phone: (____) _____

Blood Type _____

Your signature to authorize emergency medical treatment:

Name: _____ Date: _____

**Return completed form to: Mary Corwin
354 Shetland Valley Court
Chesterfield, MO 63005**

Due no later than April 1, 2023.