

Adult Medical History

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Physician's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____
Insurance Company: _____ Member ID #: _____
Group ID #: _____ Insured Name: _____

Emergency Contacts

Name: _____ Relationship to Participant: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Name: _____ Relationship to Participant: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list any conditions that a first-aid or health provider would need to know such as?

Allergies: _____

Medications: _____

Chronic Illnesses, injuries or limitations: _____

My immunizations are up to date: Yes No

In the event that reasonable attempts to contact my designated person in an emergency have not been successful, I hereby give my consent for the administration of any treatment deemed necessary by medical personnel. This health history is complete and accurate.

Signature of Participant

Date

1201323-006/2021

