

MEDICAL INFORMATION

Thursday November 29-  
Sunday December 2, 2018

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell # \_\_\_\_\_

**Person to Contact in case of an Emergency:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Telephone Number: \_\_\_\_\_

**INSURANCE INFORMATION for Emergency use only: .**

**This will be kept confidential**

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**List MEDICAL INFORMATION and MEDICATIONS that emergency personnel should know:**

Do you have any food allergies, explain?

Do you have any special needs - food, mobility...?

If yes, explain \_\_\_\_\_

(You may use the back of form if necessary)

**Please return this form with your registration. Failure to include with registration may omit you from attending.**