Name: ____

Allergies: Please List
Medical: ____
Food: ____
Other: ____
Epi Pen Y_____ N______ N/A______

Known Illnesses:
Diabetes ____ Epilepsy ____ Asthma ____ Heart Problems ____

Other- Please Explain: ____
____
____

How can we help you if the above situation occurs or becomes a problem?
____
____

Medications you Take:
____
____

Insurance Information (optional)**:**
____
____

Persons to Contact in Case of an Emergency:

1. Name: _____________________________________ Phone: ______________________________
   Relation: ___________________________________

2. Name: _____________________________________ Phone: ______________________________
   Relation: ___________________________________

Sign: ____ Date: ____________________________

All information will be kept strictly confidential and is needed to ensure prompt and proper treatment in case of emergency