2019 Mission u
HEALTH INFORMATION AND CONSENT
Please have this filled out to turn in as you register.

NAME _____ Date of Birth _____

Insurance Company _____ Policy # _____

In case of emergency, please contact: Name _____ Relationship _____

Address _____ City, State & Zip _____

Telephone Numbers _____

I am under treatment for _____

I am taking the following medications _____

I am allergic to these medications _____

My Physician is _____ Phone # _____

Primary language spoken _____

I give permission for emergency medical treatment for myself, if needed, July 18-21, 2019.

Signature _____ Date _____

We thank you for filling out the health form as completely as possible. If emergency assistance is required, our EMTs will be able to share this information so medical personnel can provide the best care possible.