

# Dodgertown West

## Health and Emergency Contact Information

This health and emergency contact form must be completed by the participant.

### Emergency Contact

Participant's Last Name	First Name	Date
Primary Emergency Contact	Day Telephone	Evening Telephone
Alternate Emergency Contact (if primary contact cannot be reached)	Day Telephone	Evening Telephone

### Health History

(Check all that apply)

<input type="checkbox"/> Bleeding or Clotting Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Heart Defect or Disease	<input type="checkbox"/> Prophylaxis
<input type="checkbox"/> Other (Describe) _____		

### Allergies

(Check all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Insect Bites/Stings (Specify) _____
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Food (Specify) _____
<input type="checkbox"/> Other (Describe) _____	

### Medications

Specify all medications currently being taken and describe any reactions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Health/Accident Insurance Information

Name of Policy Holder	Insurance Company	Policy/Group Number
Personal Physician	Physician's Telephone	