

# 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 |                     |