RLC EMERGENCY HEALTH INFORMATION

YEAR: _____

NAME: _____

DATE OF BIRTH: _____

INSURANCE COMPANY: _____

INSURANCE ID #:_____

EMERGENCY CONTACTS

NAME: _____ NAME: _____

RELATIONSHIP:_____ RELATIONSHIP: _____

PHONE #: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

_____

PHONE: _____

ALLERGIES (RX or ANY OTHER): _____

_____

_____

_____

MEDICATIONS (RX OR OTC)	DOSE	TIMES PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____