North Carolina Women of the ELCA

Event Health Form

Name_____ Event _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Primary Doctor _____ Dr.'s Phone _____

EMERGENCY CONTACTS: *If possible, one contact should be a person at the event who knows you well. If under 18, one contact must be a parent/guardian and the other should be your supervising adult attending the event.*

Emergency Contact #1: _____ Phone during event: _____

Relationship _____ Is this person attending? ___ Yes ___ No

Emergency Contact #2: _____ Phone during event _____

Relationship _____ Is this person attending? ___ Yes ___ No

MEDICAL HISTORY:

Date of Birth: _____ Last four digits of your Social Security #: _____

Primary Doctor's Name _____ Phone: _____

Insurance Company _____ Phone: _____

Allergies: (Especially list medication allergies. If your allergy is severe, circle it. If you carry an auto-injector, please note where you keep it.) _____

Medications: (Include dosage if possible. Use reverse side if needed.) _____

_____

_____

Medical Concerns: (Please list any current medical concerns of which medical personnel should be aware, for example, "Diabetes" or "Currently undergoing chemotherapy.") _____

_____

I give my permission for the NC Women of the ELCA or facility staff to call 911 and the contacts listed if I am incapacitated. I understand that this form will be kept private and only accessed in case of an emergency. It will be returned to me if requested or destroyed at the end of this event.

Signature_____ Date_____