

ACTION PROGRAM OFFICE HEALTH INFORMATION FORM

This form is to be filled out by the applicant and will be used in the case of a medical emergency

Name: _____ Sex: ____ Date of Birth: __/__/____ Age: ____

Street Address: _____ City _____ State _____ Zip _____

Home Ph: _____ / _____ - _____ Work Ph: _____ / _____ - _____ Cell Ph: _____ / _____ - _____

Spouse or Person to contact in case of an emergency _____

Street Address: _____ City _____ State _____ Zip _____

Home Ph: _____ / _____ - _____ Work Ph: _____ / _____ - _____ Cell Ph: _____ / _____ - _____

Health Insurance Carrier: _____ Policy No.: _____

Please copy the FRONT AND BACK sides of your insurance card and paperclip to this form. Do not staple.

Name of Physician: _____ Telephone: _____ / _____ - _____

Other Emergency Contacts:

Name: _____ Telephone: _____ / _____ - _____

Name: _____ Telephone: _____ / _____ - _____

Do you have any chronic health conditions we should be aware of: _____

Any activity restrictions: _____

Circle items you will have with you: Glasses Contacts Dental Devices Orthotics Other: _____

Last Tetanus vaccination (must be within the last 10 years): _____ **Please don't leave this blank!**

Diet Restrictions: _____

Allergies to Medications: _____ Type of Reaction: _____

_____ Type of Reaction: _____

_____ Type of Reaction: _____

Other Allergies: _____

Medications you will be taking every day:

Name: _____ Dosage: _____ Frequency _____

Name: _____ Dosage: _____ Frequency _____

Name: _____ Dosage: _____ Frequency _____

Name: _____ Dosage: _____ Frequency _____

Name: _____ Dosage: _____ Frequency _____

* Please note: for airport security, all medication should be in original containers.