Southeast Visual Ensemble
Health Information & Medical Form

Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____

E-mail Address: _____ **Date of Birth:** _____**Age:** _____

Emergency contact: _____ **Home Phone:** _____

Relationship: _____ *(grandparent, neighbor, etc.)* **Work Phone:** _____

Health/Accident Insurance Company:_____

Policy Holder: _____ **Relationship to member:** _____

Policy / Member ID: _____ **Group #:** _____

Known Allergies: ***(food, drugs, insects, etc.)*****:** _____

_____

_____

Special medical concerns or conditions we should know about ***(epilepsy, asthma, diabetes, old injuries to bones/joints,etc.):***_____

_____

_____

Medications currently taking: ***(dose and frequency)*****:** _____

_____

_____

Family Physician:_____**Phone:**_____

_____ _____

Your Signature **Date**

Parent/ Legal Guardian Medical Emergency Authorization is required for members under 18.

In case of emergency, we must be able to contact you. Please list your relationship and a home/cellular and work telephone number where you can be reached.

_____ **Work Telephone: (____)** _____ **Home/Cellular Telephone: (____)** _____

Relationship

_____ **Work Telephone: (____)** _____ **Home/Cellular Telephone: (____)** _____

Relationship

_____ _____

Parent/Legal Guardian **Date**