HEALTH HISTORY

NAME:_____ DOB:_____

ADDRESS:_____TELEPHONE:_____

CITY:_____ STATE:_____ ZIP:_____

Emergency Contact:_____Telephone:_____
Relationship:_____

2ND Contact, if above is not available:_____
Telephone:_____ Relationship:_____

PERSONAL PHYSICIAN:_____ TELEPHONE:_____

Insurance Carrier:_____

Policy Holder's Name:_____

Allergies:_____

Medical Conditions:_____

LIST OF CURRENT MEDICATIONS

Medication	Dosage	Medication	Dosage

IN CASE OF EMERGENCY, I hereby give my permission, in advance, to administer medical treatment and/or surgical procedures deemed necessary by a medical doctor and/or medical facility. I authorize the immediate administration of life-sustaining measures deemed necessary under the circumstances. I assume liability for any medical expenses involved. The authorization extends to my participation in any activity sponsored by the Retired and Senior Volunteer Program of Marshall County.

SIGNATURE:_____ DATE:_____