EMERGENCY HEALTH INFORMATION

Name_____ Cell Phone (____)_____

Address_____

Did you come with someone else? _____ If yes, their name: _____

In case of emergency, contact:

Name_____ Phone (_____) _____

Address_____

Medications you are taking: _____

_____

If you have medication to be taken in an emergency, where is it kept? _____

Do you have allergies? _____ If yes, please specify the allergy and the reaction you get. _____

_____

Is there any other information medical personnel should know about you? _____

_____

Medical Insurance Information

Insurance Company's Name: _____

Member ID# _____ Carrier's Phone: (_____) _____

Blood Type _____

Your signature to authorize emergency medical treatment:

Name: _____ Date: _____

This form and the MUMC Liability Waiver will complete your registration.
Return to: Mary Corwin, 354 Shetland Valley Court, Chesterfield, MO 63005
Due no later than April 1, 2021.