

# Workshop Participant Health Form

Information on this form is strictly confidential and will only be used in case of an emergency.  
Form will be returned to participant, or destroyed, at the end of the program.

Please print or type

Date of Birth
Social Security Number

## Participant Information

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Last Name	First Name	Middle
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City or Town

## Emergency Contact Information

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Name	Relationship
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Address

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Phone Numbers	Home	Work
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Additional Contact Numbers (pager, cell phone)

## Health Insurance Information

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Company or Organization

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Address	Phone Number
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Policy or Contract Number	Expiration Date
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## Physician(s)

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Name

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Address	Phone Number
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## Medical Information

Do you have a Medic Alert tag/bracelet? (if yes, for what condition)

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Allergies (food, insects, medications, others)

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Do you carry medications for your allergies? (if yes, list medication(s) and dosages)

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Current medications (include herbal and over the counter medications as well as prescription medications, including birth control pills)

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### Pertinent Medical History

(please list medical conditions e.g., diabetes, asthma, seizures, etc. or physical conditions that might be important for emergency care.)

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### Special Beliefs

(any religious or other beliefs that might have an impact on medical care, such as blood transfusions, etc.)

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### Important Notice:

This form contains medical information that accurately reflects known medical conditions and medications I am currently taking.

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Participant's Name

Participant's Signature

Date