DOXA

EMERGENCY & MEDICAL INFORMATION

NAME: _____ BIRTH DATE: _____
HOME PHONE: _____ CELL PHONE: _____
EMAIIL: _____

MEDICAL INFORMATION
***MANDATORY*:** Date of last Tetanus shot: _____
Do you experience any of the following & please explain:
□ Asthma attacks (include exercise-induced asthma):
_____**If yes, you **must** bring full inhaler.*
□ Chronic/Recurring illness _____
□ Physical handicap or physical activity limitations: _____
□ Please list and explain any other health conditions we should be aware of:
_____

ALLERGIES & RESTRICTIONS: Please list all allergies and restrictions.
Food Restrictions (vegetarian/vegan preference and allergies): _____
Medications/Medical: _____
Environmental: _____

MEDICATIONS: Please list **ALL** medications currently being taking ***(mandatory)***
Medication Type of illness being treated Dosage/Special Instructions
1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

EMERGENCY CONTACT INFORMATION *(mandatory)*
Contact #1 _____ Contact #2 _____
Phone: _____ Phone: _____
Cell Phone: _____ Cell Phone: _____
Contact (if above cannot be reached): Name: _____Phone:_____

INSURANCE INFORMATION *(mandatory)*
Name of Insurance Company: _____ Phone: _____
Policy Holder Name: _____ Policy Number: _____

LIABILITY & RELEASE INFORMATION
In the event that ANY insurance, medical, or emergency contact information changes it is the responsibility of the leader to update the Emergency & Medical Information Form. Any and all financial charges incurred in the event of an emergency are the sole responsibility of the leader or family of the leader. In the event of medical treatment, all expenses will be directly billed by the medical provider to the leader/family. If the medical provider requires payment at the time services are rendered for the leader and DOXA advances such payment (with the acknowledgment that DOXA is not required to do so), the leader/family agrees to reimburse DOXA for the full amount of such payment.

Signature: _____ Date: _____