

Cloudcroft United Methodist Church

Medical Information

Name _____ Birthdate _____

Insured person

Emergency Contact:

#1 _____

Name & relationship

Phone #

#2 _____

Name & relationship

Phone #

Name of Insurance Co. _____

Group and/or policy # _____

Social Security #(if needed for insurance i.d.) _____

MEDICAL CONDITIONS TO BE AWARE OF:(Please check if none) NONE _____

ALL KNOWN ALLERGIES INCLUDING MEDICINES: NONE _____

MEDICATIONS CURRENTLY BEING TAKEN: NONE _____

Parent (or legal guardian) _____

Date _____