**Health Information Form – EFM**

**Name** \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB Your Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address Gender M F Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food/Drug/Insect Allergies

Date of Last Tetanus Shot Height Weight

**Emergency Contact Information**

Name Relationship Phone #

Name Relationship Phone #

**Insurance - You MUST provide a copy of the front and back of your insurance card. Please make copies prior to registration.**

Policy Holder’s Name Relationship Phone Number

Policy Holder’s Employer

Insurance Provider Policy # Plan #

Primary Care Physician Physician’s Phone #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant Date

**Current Prescription and Over-the-Counter Medications** - Medications must be provided in the original containers. This includes over-the-counter medications.

Name of Medication Dose Time(s) to be Taken Reason for Medication

 \_\_\_\_\_\_

**Specific concerns/physical restrictions/accommodations** (e.g. recent changes) \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_