Southwestern Adventist University and Earth History Research Center

Medical Information

Name (print): _____ **Date of Birth** (mm/dd/yy)**:____/____/____**

Address: street _____

city _____ state _____ zip _____ country _____

phone (___) _____ e-mail _____

Emergency Contact Person: _____ phone: (___) _____

Medical Insurance Company: _____

policy of group number: _____

restrictions on coverage: _____

_____

Personal Physician: _____ phone: (____) _____

Date of last Tetanus booster (mm/yy): _____/_____ given by: _____

Describe any restrictions on your physical activity:

_____

_____

Medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies to medicines and/or acute allergies to environmental allergens (bee sting, pollen, horses, etc) and/or other conditions that might lead to an acute situation requiring an immediate response:

_____

_____

_____

I hereby attest that the above information is complete and correct.

SIGNATURE _____ date _____

If a minor, parent or guardian signature_____ date _____