



CALMS
11906 Manchester Road, Suite 110
St. Louis, MO 63131
(314) 640-4830
www.calms.org

EMERGENCY MEDICAL INFORMATION

Applicant's Name: _____

Address: _____
Street City State Zip

Phone Number: _____

Gender: M F Age: _____

Birth Date: _____

Parent's Name (If covered by their insurance policy): _____

Parent's Phone (If different from above): _____ Work Phone: _____

Health Information: To Be Completed By All Participants

Describe your general health condition: _____

Do You Have: (If "Yes", please explain)

1. Drug Allergies?
 Yes
 No
Please explain:
2. Food Allergies?
 Yes
 No
Please explain:
3. Special Dietary Needs (Foods you need to avoid)?
 Yes
 No
Please explain:
4. Environmental Allergies?
 Yes
 No
Please explain:
Has any allergic reaction required emergency room care?
5. Heart Condition?
 Yes
 No
Please explain:



6. Diabetes?
 Yes
 No
Please explain:
Is your diabetes controlled by: diet oral medication insulin
7. Contact Lenses?
 Yes
 No
Please explain:
8. Have you had any serious illness or surgery within the past three years?
 Yes
 No
Please explain:

Are You Subject To: (If “Yes”, please explain)

1. Fainting?
 Yes
 No
Please explain:
2. Sleep Walking?
 Yes
 No
Please explain:
3. Insomnia?
 Yes
 No
Please explain:
4. Snoring?
 Yes
 No
Please explain:
5. Upset Stomach?
 Yes
 No
Please explain:
6. Any condition that would prevent you from participating in any activities?
 Yes
 No
Please explain:

Are You: (If “Yes”, please explain)

1. A Smoker?
 Yes
 No
Please explain:



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Please indicate ANYTHING else that the leaders should know to help deal with any situation that might arise:

LIST ALL CURRENT MEDICATION, DOSAGE AND WHAT IT IS BEING TAKEN FOR:

Emergency Information (MUST BE INCLUDED):

Health Insurance Company: _____ Policy #: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____
Street City State Zip

Home Telephone: _____ Work Telephone: _____

Primary Physician: _____ Telephone: _____

Insurance Beneficiary: _____