

# PHYSICAL HEALTH NOTIFICATION FORM

This form is for emergency purposes only. In the event you should become injured or incapacitated, we would have immediate information available for paramedics so that they can tend to your needs.

\_\_\_\_\_  
Name Phone

\_\_\_\_\_  
Address City Zip

\_\_\_\_\_  
Date of Birth

Have you currently, or have you had any of the following?  
(Please check, explain and date each Yes answer.)

- Joint or mobility problems \_\_\_\_\_  
\_\_\_\_\_
- Surgeries \_\_\_\_\_  
\_\_\_\_\_
- Sports injuries \_\_\_\_\_  
\_\_\_\_\_
- Head injuries/concussions \_\_\_\_\_  
\_\_\_\_\_
- Contact lenses \_\_\_\_\_  
\_\_\_\_\_
- Allergies \_\_\_\_\_  
\_\_\_\_\_
- Allergies to medications \_\_\_\_\_  
\_\_\_\_\_
- Currently taking medications (names and why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Any other physical limiting conditions we should be made aware of \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If known, your personal health insurance company

\_\_\_\_\_  
Group / Company Name Phone

Who do we contact in case of an emergency?

\_\_\_\_\_  
Name Phone

\_\_\_\_\_  
Signature Date