MEDICAL INFORMATION FORM

OFFICE USE:
INSURANCE # - YEAR
_____-_____
_____-_____
_____-_____
_____-_____
_____-_____
_____-_____

GOEBEL SENIOR CENTER COMMISSION

CONEJO RECREATION & PARK DISTRICT

Name:_____

Address:_____City:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Other:_____

Email:_____ Birthday:_____

Do you have any health problems that we should be aware of?

___High Blood Pressure ___Heart Condition ___Pace-Maker
___Difficulty Walking ___Diabetes ___Poor Vision
___Poor Hearing ___Other:_____

Do you take any medications prescribed by a doctor? ___No ___Yes

Name and dosage taken:_____

Do you take any medications that must be administered in the case of an emergency?

___No ___Yes: Name and dosage taken: _____

Are you allergic to any medication? ___No ___Yes

If yes: (name of medication)_____

Do you have any food allergies? ___No ___Yes

If yes: (please list)_____

Personal Physician Name: _____ Phone:_____

and/or Insurance Company: _____ Phone: _____

Who should we contact in case of emergency?

Name	Relationship	Phone number	Cell or work number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that the Goebel Senior Center Commission Accident Medical coverage is a secondary coverage and that I am only covered by it when I am participating in a Goebel Senior Adult Center sponsored program.

Signature_____ Date_____

Last Name