MO-HAB EMERGENCY HEALTH INFORMATION

Name___________________________________ Cell Phone (____)_________________________

Address____

Did you come with someone else? _____ If yes, their name: _____________________________

In case of emergency, contact:

Name____________________________________ Phone (_____) _________________________

Address____

Medications you are taking: ____

____

If you have medication to be taken in an emergency, where is it kept? ______________________

Do you have allergies? _____ If yes, please specify the allergy and the reaction you get. _______

____

Is there any other medical information we should know about you? ________________________

____

Insurance Company's Name: ____

Member ID# ______________________________ Carrier's Phone: (_____) ________________

Blood Type __________

Your signature to authorize emergency medical treatment:

Name: ____ Date: __________________

Return completed form to: Mary Corwin
354 Shetland Valley Court
Chesterfield, MO 63005

Due no later than May 1, 2024