

**Medical Information Form**  
**CONFIDENTIAL**

We realize that this is personal information, and assure that it will remain confidential. Only provide us with information you feel comfortable giving, as none of this information is mandatory. However, these are questions that will be asked of us in case of an emergency, and having it handy will help us assist you as quickly and efficiently as possible.

Please return this form to your Stage Manager. Thank you.

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Permanent Home Phone #: \_\_\_\_\_

Permanent Home Address: \_\_\_\_\_

Health Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Group / Policy ID #: \_\_\_\_\_

Insurer's Name (if not held by you): \_\_\_\_\_

Family Physician Name & Phone #: \_\_\_\_\_

Please list any medications you are taking (including dosage information), any allergies you have (medications or non), pre-existing medical conditions, or any other pertinent medical information below that would help us aid you. Every detail helps.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Name, Phone # and Relationship to you: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_