Center for American Archeology
Adult Medical Form

Please fill in this medical history form as completely as possible. The information contained herein will be kept strictly confidential and may be helpful to us in case of an emergency medical situation during your stay with us.

Name:_____ Birthdate:_____

Address:_____

City/State/Zip:_____ Home Phone #:_____

In case of emergency please contact:

Name:_____ Relationship:_____

Address:_____ Phone #:_____

City/State/Zip:_____ Cell/Second #:_____

Personal Medical Information:

Medical Insurance Company:_____

Plan & Policy #:_____

Do you have any allergies? Please answer with a yes or no:

To insects: _____ Specify: _____

To pollen: _____ Specify: _____

To foods: _____ Specify: _____

To medications: _____ Specify: _____

Date of last tetanus shot: _____ *(required for attendance)*

Do you have any physical disabilities that we should know about? Yes ___ No ___

Specify: _____

Is there anything else about your health status that we should know in order to ensure your safety and well-being while in residence? (e.g. hypoglycemia, diabetes, etc.) Yes ___ No ___

Specify: _____

Signature: _____ Date: _____