Emergency Information

In case of emergency please notify:

Name _____ Relationship _____

Mailing Address _____ City _____ State _____ Zip Code _____

Telephone (Home) _____ (Office) _____

1. **Are you allergic to any medications?** YES NO
   If yes, what?

2. **Are you currently taking any medication?** YES NO
   If yes, what?

   What is this medication taken for?

   How often do you have to take the medication?

3. **Do you have any food allergies?** YES NO
   If yes, what foods?

4. **Do you require a special diet?** YES NO
   If yes, please explain:

5. **Are you currently under the care of a physician?** YES NO
   If yes, for what?

6. **Do you have medical insurance?** YES NO
   If yes, please fill in the following, and attach a copy of your health insurance card to this form.

   Name of Insurance Carrier: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Policy #: _____

7. Have you had a tuberculosis test within one year from the start of the SALT program? YES NO
   Please attach the results of a recent Tuberculosis test to this form.

I hereby affirm that the above information is accurate to the best of my knowledge.

Name (PLEASE PRINT): _____ Date: _____