



# 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: \_\_\_\_\_