



Emergency Information

NOTE: PLEASE DO NOT FAX OR EMAIL THIS FORM.

Send with 1) negative tuberculosis test and 2) copy of front and back of health insurance card to:
Sr. Mary Donovan, 600 Woods Road, Germantown NY 12526

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: _____