JURISDICTIONAL GUARDIAN COUNCIL OF MONTANA
JOB'S DAUGHTERS INTERNATIONAL
PERSONAL HEALTH FORM
ADULTS

Event for which the following information is requested: ____

Date(s) of activity: ________________________

The information provided in this form will be used at the discretion of the Bethel Guardian council to ensure that care and attention are given to the health of the adult listed below should an emergency arise.

Name: ____ Date of Birth: ______________________
(First Name) (Last name) (Year/Month/Day)

Address: ____ Height: _________ Weight: ________
(Street)

____
(City) (State/Province) (Zip/Postal Code)

In case of an emergency please notify:

Name: ____ Phone: Home (_____) _______________
(Name) (Relationship)

Address: ____ Other (_____) _____________________

Insurance Carrier: ____ Policy #: __________________________

Family Doctor: ____ Phone: (_____) ____________________

Do you have allergic reactions to such things as drugs, food, insect stings, etc? If so, please list, giving type of reaction, treatment given, etc.: ____

____

Please list any chronic conditions or recent illnesses of which the Bethel Guardian Council should be aware: __________

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____

Please specify details of medication or treatment required for the above (be as specific as possible): _________________

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Other information you feel needs to be listed: ____

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Date of last tetanus shot: _____________ Do you require corrective lenses? ________ Contact lenses? _______