THE ROMAN CATHOLIC
DIOCESE OF LAS CRUCES

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HEALTH AND MEDICAL INFORMATION

Name_____

Family Physician _____Phone _____

Medical Plan _____Plan# _____

*Do you authorize medical treatment for yourself in an emergency, as considered necessary by the attending physician?
_____Yes _____No

Please attach a copy of your insurance card (front and back).

State any reasons why you do not want medical care given to you in an emergency: _____

_____

List your allergies: _____

_____

_____

List all conditions (such as allergies, seizures, asthma, diabetes) for which you require ongoing medication and state the type and frequency of medication taken: _____

_____

_____

List all food allergies:

_____

_____

In case of emergency, contact: _____

Home or Work Phone_____**Cell Phone**_____

Signature of Participant_____**Date** _____