Emergency Contact & Medical Information

Required Before First Session · Kept On File

This form provides Paul with the information needed to respond quickly and effectively in an emergency. It is kept on file and updated as needed. Complete all sections as fully as possible.

Client Information

FULL LEGAL NAME

DATE OF BIRTH

CELL PHONE

EMAIL ADDRESS

HOME ADDRESS

Primary Emergency Contact

CELL PHONE

HOME / OTHER PHONE

Primary Care Physician

PHYSICIAN NAME

PRACTICE / CLINIC NAME

PHONE NUMBER

ADDRESS / CITY

Medical Information

KNOWN ALLERGIES (INCLUDE REACTION TYPE)

CURRENT MEDICATIONS & SUPPLEMENTS

BLOOD TYPE (IF KNOWN)

HEALTH INSURANCE PROVIDER

INSURANCE MEMBER ID / POLICY NUMBER

INSURANCE PHONE NUMBER

CHECK ANY MEDICAL CONDITIONS THAT APPLY:

- ☐ Diabetes (Type 1 or Type 2)
- ☐ Heart condition / coronary artery disease
- ☐ Arthritis or joint disease
- ☐ Osteoporosis / low bone density
- ☐ Anxiety / depression
- ☐ High blood pressure
- ☐ Asthma or respiratory condition
- ☐ Neurological condition (e.g., epilepsy)
- ☐ Chronic pain condition
- ☐ Other: _____

MEDICAL CONDITIONS RELEVANT TO EXERCISE (DETAIL ANY FLAGGED CONDITIONS):

DO YOU CARRY AN EPIPEN OR EMERGENCY MEDICATION? (CIRCLE ONE): YES / NO

PREFERRED HOSPITAL / FACILITY (IF ANY)

ANY OTHER HEALTH INFORMATION PAUL SHOULD KNOW FOR EMERGENCY RESPONSE:

Emergency Treatment Authorization

In the event that I am unable to communicate in a medical emergency, I authorize Paul Gover to: (1) call 911 and request emergency medical services; (2) contact my emergency contacts listed above; (3) provide basic first aid within his training and certification; and (4) provide responding emergency personnel with the medical information listed on this form.

Signatures

CLIENT SIGNATURE

PRINTED NAME

DATE

DATE

Please update this form any time your emergency contacts, medications, or medical information changes. Notify Paul directly of any urgent changes.

Additional Medical Notes