BLACK SWAMP QUILTERS GUILD RETREAT MEDICAL FORM

YOUR NAME: _____

YOUR PHONE #: _____

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE #: _____

RELATIONSHIP: _____

PRIMARY DOCTOR

NAME: _____

PHONE #: _____

PRIMARY DENTIST

NAME: _____

PHONE #: _____

MEDICATIONS YOU ARE TAKING

Medication		Medication	
Dosage		Dosage	
How often		How often	
Medication		Medication	
Dosage		Dosage	
How often		How often	

LIST ALLERGIES: _____

_____

_____

OTHER INFORMATION NEEDED TO HELP MEDICAL PERSONNEL IN CARING FOR YOU IN AN EMERGENCY: _____

_____

_____

PLEASE BRING COMPLETED FORM, IN A SEALED ENVELOPE, TO RETREAT.
PLEASE PUT YOUR NAME ON THE ENVELOPE AND PUT UNDER
YOUR MACHIINE.