FORM 6

12TH US INFANTRY
COMPANY A
HEALTH FORM

Name: _____ Home phone: _____

Address: _____ Cell phone: _____

City/Town: _____ Work Phone: _____

State: _____ Zip: _____

Doctor: _____ Doctor phone: _____

Insurance Company: _____ Policy/Plan #: _____

Relative/contact person: _____ Phone: _____

Contact person address: _____

2nd. Contact person: _____ Phone: _____

Address: _____

Allergies/Medical Conditions (Describe): _____

Medications (List with dosage): _____

Reactions (please note severity) and treatment: _____

_____

Other Information (such as where you store your meds while reenacting): _____

_____

Date: _____ Updated: _____

Signature: _____
