ARIZONA CIVIL WAR COUNCIL INC
MEDICAL FORM

This form should be carried on person and on file with Commander

Form should be updated as needed.

Name _____ Age _____

Address _____ D.O.B. _____

Phone _____ Blood Type (if known) _____ Sex _____

Doctor's Name _____ Phone _____

Next of Kin _____ Phone _____ Relation _____

Insurance Company _____ Insurance No. _____

Allergies (list all – i.e. to medicine, food, plants or animals): _____

_____

_____

Health problems (list all – i.e. heart, respiratory, blood pressure, asthma, diabetes or any other): _____

_____

_____

_____

Medicine taken (please list name, dosage and how often): _____

_____

_____

Place where you keep your medicine while in camp: _____

_____

Do you have a Living Will? If so where? _____

_____

I hereby give all Doctors, Nurses, or other Emergency personnel my permission to give all reasonable treatment to me if I'm not capable of giving my permission. If I am under the age of 18, my parents give permission for me to have all reasonable treatment until they can be reached.

_____ _____

Name (Signature) Date