Sangre de Cristo Youth Ranch

Sr. Staff Medical History

Staff member name: _____

EMERGENCY CONTACT
#1 Name: _____
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell: (____) _____-_____
#2 Name: _____
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell: (____) _____-_____

ALLERGIES
Please list all known allergies. Describe allergy (food, medicine, environmental, etc.), reaction to allergen, and management of reaction: _____
_____
_____

☐ **Vegetarian meals** ☐ **Vegan meals** ☐ **Other:**_____

MEDICATION
Please list all medications (including over the counter or nonprescription drugs) taken routinely.

Med #1: _____ Dosage: _____ Specific times taken each day: _____
Reason for Taking: _____
Med #2: _____ Dosage: _____ Specific times taken each day: _____
Reason for Taking : _____
Med #3: _____ Dosage: _____ Specific times taken each day: _____
Reason for Taking: _____

INSURANCE
Are you covered by medical/hospital insurance?: ☐ Yes ☐ No
If yes, carrier or plan name: _____ Group #: _____
Please attach a photocopy of health insurance card.

Mail To: **Localogy**
HC 81 Box 41
Questa, NM 87556