



# Emergency Contact & Medical Information

Required Before First Session · Kept On File

DO YOU CARRY AN EPIPEN OR EMERGENCY MEDICATION? (CIRCLE ONE): \_\_\_\_\_ PREFERRED HOSPITAL / FACILITY (IF ANY) \_\_\_\_\_  
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.  
ANY OTHER HEALTH INFORMATION PAUL SHOULD KNOW FOR EMERGENCY RESPONSE: \_\_\_\_\_

## Client Information

FULL LEGAL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
**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.

## Primary Emergency Contact

### 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.

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): \_\_\_\_\_  
\_\_\_\_\_

## Additional Medical Notes