Revolutionary War Days
Nevada City
Reenactor Medical Form

Name: ____

Do you have any allergies? ____

Are you taking any prescription medicine? __________________________________

Do you have any other medical condition which would affect your participation?
____

In case of emergency please notify: (Name) __________________________________

Home phone: ____

Cell: ____

Address: ____

Health care provider: ____

Policy Number: ____

Doctor: ____

Phone: ____

I authorize the release of this information to emergency medical personnel.

Signature: ____

Date:____

(If under 18 parent or guardian must sign as well.)