Personal Information:

Name

Phone Number Birth Date

Emergency Contact Phone Number

Primary Physician Phone Number

Date this form was completed

Medical Information:

Chronic Conditions:

- ☐ Heart Disease
- ☐ Breathing Problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Other _____
- ☐ Other _____

Medication & Other Allergies:

Notes:

Prescription Medications:

Name	Dose	Frequency of Use
Name	Dose	Frequency of Use
Name	Dose	Frequency of Use
Name	Dose	Frequency of Use

Over - the Counter Medications:

Name	Dose	Frequency of Use
Name	Dose	Frequency of Use
Name	Dose	Frequency of Use

Vitamins:

Name	Dose	Frequency of Use
Name	Dose	Frequency of Use

Herbal Medications:

Name	Dose	Frequency of Use
Name	Dose	Frequency of Use

PLEASE NOTE: In order to protect your privacy, this information will be kept confidential and will only be used in case of a medical emergency.

This document will be destroyed at the conclusion of the 2026 NLS AG on July 26, 2026.