12TH VIRGINIA INFANTRY COMPANY B
LONGSTREET'S CORPS

MEMBER HEALTH AND MEDICAL INFORMATION
TO BE USED ONLY IN AN EMERGENCY AS AUTHORIZED BY THE MEMBER

PLEASE PRINT CLEARLY

I. MEMBER IDENTIFICATION

LAST NAME	FIRST NAME	M.I.	NICK NAME

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	DATE OF BIRTH	SEX	MOTHER'S MAIDEN NAME

INSURANCE COMPANY NAME	POLICY HOLDER NAME	POLICY IDENTIFICATION #	GROUP#

II. PLEASE NOTIFY:

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

PRIMARY CARE PHYSICIAN	TELEPHONE

SPECIAL INSTRUCTIONS/CONSIDERATIONS:

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____
____
____
____

ENCLOSURES (CHECK EACH ITEM):

_____ COPY OF INSURANCE CARD(S)
_____ COPY OF DRIVER'S LICENSE OR OTHER IDENTIFICATION
_____ ADDITIONAL MEDICATION LIST

NAME: ____

III. PERTINENT MEDICAL HISTORY

LIST **ANY** ALLERGIES TO MEDICATION, FOODS, INSECTS/ANIMALS OR PLANTS.
INCLUDE THE **TYPE** OF REACTION (HIVES, RASH, ANAPHYLACTIC SHOCK, ETC.):

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____

LIST **ALL** CURRENT MEDICATIONS. **INCLUDE DOSAGE AND SCHEDULE.**
(ATTACH SEPARATE SHEET IF NECESSARY):

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WHILE ON EVENTS, **WHERE** DO YOU KEEP YOUR MEDICATIONS?

____

DO YOU HAVE OR HAVE YOUR EVER SUFFERED FROM THE FOLLOWING? PLEASE MARK CLEARLY.

__ HEADACHE/MIGRAINE	__ FREQUENT COUGH	__ ANGINA	__ INDIGESTION
__ FAINTING/DIZZINESS	__ BRONCHITIS/PNEUMONIA	__ RHEUMATIC FEVER	__ HEARTBURN
__ EPILEPSY/SEIZURE	__ ASTHMA/WHEEZING	__ PHLEBITIS	__ ULCERS
__ STROKE	__ SHORTNESS OF BREATH	__ HEART DISEASE	__ VOMITING OF BLOOD
__ FREQUENT NOSE BLEEDS	__ PLEURISY	__ ARTHRITIS/JOINT PAIN	__ LIVER DISEASE
__ CONTACT LENSES/GLASSES	__ HEART PALPITATIONS	__ BACK/NECK PAIN (INJURY)	__ KIDNEY DISEASE
__ BLEED/BRUISE EASILY	__ CHEST TIGHTNESS/PRESSURE	__ TROUBLE SWALLOWING	__ ANEMIA

LIST **ALL CURRENT** HEALTH CONDITIONS THAT MAY REQUIRE SPECIAL CARE, MEDICATION OR DIET:

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____

LIST **ANY PAST** HEALTH CONDITIONS, SURGERIES, SYMPTOMS, OR INJURIES THAT MAY INFLUENCE TREATMENT:
(PLEASE INCLUDE DATES AND DETAILS)

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____
____

HAS THERE EVER BEEN ANY RESTRICTION OF PHYSICAL ACTIVITY FOR MEDICAL REASONS?

____
____

NAME: ____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I AM ABLE TO PARTICIPAE FULLY IN ANY ACTIVITY OF THE 12TH VIRGINIA INFANTRY, COMPANY B, SUBJECT ONLY TO LIMITATIONS AS STATED. ABOVE. IN THE EVEN OF ILLNESS OR INJURY SUSTAINED DURING THE COURSE OF SUCH ACTIVITY, I REQUEST THAT MEDICALATTENTION BE ADMINISTERED WITHOUT DELAY AS DICTATED BY MEDICAL PERSONNEL.

____ ____________________

SIGNATURE DATE

____ ____________________

PARENT/GUARDIAN (IF MEMBER UNDER AGE 18) DATE

OPTIONAL:

PLEASE RELEASE ANY INFORMATION REGARDING MY TREATMENT OR CONDITION TO THE MEMBER(S) OF THE 12TH VIRGINIA ACCOMPANYINGME, IF NO FAMILY MEMBERS ARE AVAILABLE.

____ ____________________

SIGNATURE DATE

____ ____________________

PARENT/GUARDIAN (IF MEMBER UNDER AGE 18) DATE