To Be Opened Only In The Event Of An Emergency (Place in sealed envelope with your name on outside)

CCT Member Medical Data Sheet

Date: _____

Name (First, Middle, Last			Date of Birth
Address/City/State/Zip			Home Phone No.
Secondary Address (Lake House, Cabin, Condo etc.)			Secondary Home Phone No.
Blood Type	Prominent Scars or Marks (Tattoos)	Religion	Work Phone No.
Insurance Company Name	Insurance Company Phone No.	Insurance Company Group No.	Insurance Company Patient No.
In Case of Emergency - Notify			Phone No.
Physician's Name	Physician's Phone No.	Dentist's Name	Dentist's Phone No.

Physical Restrictions (e.g., Heart, Asthma, Diabetic, etc.)

Rx/Special Medications Required (Please List):

MEDICATION(S) YOU ARE ALLERGIC TO (Please List):

Spouse, Children and/or Other Persons to Notify in Emergency

Name	Relationship	Phone No.	Age
Name	Relationship	Phone No.	Age
Name	Relationship	Phone No.	Age
Name	Relationship	Phone No.	Age
Name	Relationship	Phone No.	Age

Fill out form online then print ***For Emergency Use Only*** **Confidential Medical Information**