

Motion Picture/Television

Course Name and Number:			
Prod. #:		Production Title:	
Producer:		Director:	

EMERGENCY MEDICAL INFORMATION FOR CAST

NAME:		SS#:
LOCAL ADDRESS:		
PHONE:		

Parent(s), relative(s) or person(s) to be notified in case of emergency:

NAME:		NAME:	
ADDRESS:		ADDRESS:	
PHONE:		PHONE:	

Physician to be notified in case of emergency:

NAME:	
ADDRESS:	
PHONE:	24 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO

PERSONAL INFORMATION

Blood Type:	Date of last Tetanus Shot:
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Any allergies that cause acute reactions? YES NO If YES, please explain below.

Any important medical information that an emergency physician should know (diabetes, epilepsy, hemophilia, etc.)? YES NO If YES, please explain below.

Are you currently on any medication? YES NO If YES, please explain below.

Name, address, and policy number of any health/medical insurance plan. If none, write "NONE":

PLEASE USE REVERSE SIDE FOR ANY ADDITIONAL INFORMATION OR COMMENTS.