



**Fayette County  
Participant Personal Information**

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

(PHONE)

(RELATIONSHIP)

PHYSICIAN NAME \_\_\_\_\_ PHONE \_\_\_\_\_

LIST THE NAME OF YOUR MAJOR MEDICAL HEALTH INSURANCE COMPANY AND THE POLICY NUMBER:

(INSURANCE COMPANY)

(POLICY #)

LIST ANY KNOWN ALLERGIES OR MEDICAL PROBLEMS: \_\_\_\_\_

Do you currently have a history of:

Yes

No

Diabetes

High Blood Pressure

Back Problems

Emphysema

Asthma

Heart Problems

Pacemaker

Other \_\_\_\_\_

List any medications with time and dosage: \_\_\_\_\_

Adverse reactions if medications are not taken as prescribed: \_\_\_\_\_

Do you need a modification due to disability to enjoy this program? Check one:  Yes  No

In case of emergency, I give my permission for a Recreation Department representative to collect my belongings and seek immediate medical attention for myself. I have read and agree to all of the above.

(Signature)

(Date)