GALAXY EMERGENCY CONTACT INDIVIDUAL

<table>
<tr><td colspan="4"><u>Full Name:</u></td><td colspan="3"><u>AGE</u>:</td></tr>
<tr><td colspan="2"><u>Primary Address (Mailing)</u></td><td colspan="2"><u>City</u></td><td><u>State</u></td><td><u>County</u></td><td><u>Zip Code</u></td></tr>
<tr><td colspan="2">Physician Name:
Physician Phone Number:
Physician Address:</td><td colspan="5"><u>Preferred Hospital</u>: Address:</td></tr>
<tr><td><u>Gender</u>
Male
Female</td><td><u>Birth Date</u></td><td colspan="2"><u>Advanced Directives:</u></td><td colspan="3"><u>Cell Number:</u>
Home:
Work:</td></tr>
<tr><td colspan="7"><u>Emergency Contact #1 Information</u>
Name: Relationship to individual:
Address:
Cell: Work: Home:
<hr><u>Emergency Contact #2 Information</u>
Name: Relationship to individual:
Address:
Cell: Work: Home:
<hr>Medical Insurance Information/plan type: .
Policy Number:
Group Number:
Insurance Plan Provided Through Name: DOB:</td></tr>
<tr><td colspan="3">Allergies: No, Yes.
Epi Pen in possession: No, Yes
Have you used Epi Pen in the past? No, Yes
If yes see next page</td><td colspan="2">Seizure Disorder:
No, Yes.
Meds in possession No, Yes
If yes see next page</td><td colspan="2">Heart Condition:
No, Yes.
Diabetes:
No, Y
If yes see next page</td></tr>
</table>

SIGNATURE: ***DATE:*** ***RELATIONSHIP:***

GALAXY EMERGENCY CONTACT INDIVIDUAL

Please fill out this form if you have medical concerns we need to know about:

Allergies: **Action:**

Allergy	Give Benadryl	Give Epi Pen	Prior Hospitalization	Symptoms if exposed
	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	
	Yes No	Yes No	Yes No	

COMMENTS:

Please Describe in further detail any MEDICAL CONCERNS we need to know about:

Please list any SPECIAL ACCOMMODATIONS you may need:

Please list any Medical INSTRUCTIONS that would be helpful for Galaxy Staff to Understand:

***If Galaxy staff feel it is necessary to call 911 we will do so even if another plan is indicated on this form.**

SIGNATURE: ***DATE:*** ***RELATIONSHIP TO INDIVIDUAL:***