**THIS FORM MUST BE COMPLETED, SIGNED AND RETURNED.**

***ESTA FORMA SE DEBE COMPLETAR, FIRMAR Y SE DEBE DEVOLVER.***

|  |  |  |  |
| --- | --- | --- | --- |
| **(Please Print / *Por favor de imprintar*)** | | | |
| NAME / *NOMBRE* | | | |
|  | | | |
| Last Name/*Apellido* First / *Nombre* Middle Initial / *Inicial* | | | |
|  | | | |
| BIRTHDAY /  *FECHA DE NACIMIENTO* |  | EMAIL ADDRESS |  |
| Month/Mes – Day/Día – Year/Año | | | |
| HOME ADDRESS/  *DOMICILIO* |  | | |
| City/Ciudad Zip/Zona Postal | | | |
| MAILING ADDRESS/  *DIRECCION* |  | | |
| City/Ciudad Zip/Zona Postal | | | |

**In case of emergency, illness, or accident to the above named person, the company is authorized to proceed as indicated below in order of preference: Use 1, 2, 3, etc., to indicate preference. *(En caso de emergencia, enfermedad, o acidente al nombrado, el trabajado tiene la autoridad a proceder como es indicado abajo en la orden de preferencia: Use 1,2,3, etc., para indicar su preferencia.)***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ( ) Contact/  *Contacto* |  | | |  | Office Phone/  *Teléfono del Trabajo* |  |
|  | Name/*Nombre* | | | Relation |  |  |
| Home Phone *Teléfono de Casa*/ | | |  | | Cell Phone/  *Teléfono Cellular* |  |
| ( ) Contact /  *Contacto* |  | | |  | Office Phone /  *Teléfono del Trabajo* |  |
|  | Name/*Nombre* | | | Relation |  |  |
| Home Phone/ *Teléfono de Casa* | | |  | | Cell Phone/  *Teléfono Cellular* |  |
| ( ) Other/  *Otro* |  | | | | Office Phone /  *Teléfono del Trabajo* |  |
|  | Name/*Nombre* | | | |  |  |
| Home Phone/ *Teléfono de Casa* | | |  | | Cell Phone/  *Teléfono Cellular* |  |
| ( ) Friend/  *Amigo(a)* |  | | | | Office Phone/  *Teléfono del Trabajo* |  |
|  | Name/*Nombre* | | | |  |  |
| Home Phone/ *Teléfono de Casa* | | |  | | Cell Phone/  *Teléfono Cellular* |  |
|  | |  | | |  |  |
| Family physician/  *Médico familiar* | |  | | | Phone/  *Teléfono* |  |
|  | | Name/*Nombre* | | |  |  |

**Check if you have any of the following conditions/ *(Marque cualquier de las siguientes condiciones tiene usted)***

❏ **Diabetes**/*Diabetes* ❏ **Epilepsy**/*Epilepsia* ❏ **Hemophilia**/*Hemofilia* ❏ **Heart Condition**/*Condiciones del corazón* ❏ **Asthma**/*Asma*

**History of severe allergic reactions to: Other:**

*Historia de reacciones alergicas a:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Otro: \_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List medications you regularly take at home** *(Lista medicaciones usted toma regularmente en su casa)*