

# The MVP Health Care Bitter Pill

## Emergency Contact & Medical Information

Your Name: \_\_\_\_\_

\_\_\_\_\_  
Primary Emergency Contact Name

\_\_\_\_\_  
Secondary Emergency Contact Name

\_\_\_\_\_  
Primary Emergency Contact Relation

\_\_\_\_\_  
Secondary Emergency Contact Relation

\_\_\_\_\_  
Primary Emergency Contact Phone Number

\_\_\_\_\_  
Secondary Emergency Contact Phone Number

### Medical Information

Are you currently taking any medication? If so, please list.

\_\_\_\_\_  
\_\_\_\_\_

Have you had any surgeries within the past five years? If so, please describe.

\_\_\_\_\_  
\_\_\_\_\_

Do you have allergies to any medications? If so, please describe.

\_\_\_\_\_  
\_\_\_\_\_

Is there any other medical conditions we should be aware of?

\_\_\_\_\_  
\_\_\_\_\_

Are you currently under a physician's care? If so, please explain.

\_\_\_\_\_  
\_\_\_\_\_

**Seal this form in a standard envelope with your full name and team name written on it.**

**The envelope will only be opened in the event of an emergency.**