

PURDUE UNIVERSITY THEATRE
CONTACT/EMERGENCY INFORMATION FORM

CONTACT INFORMATION

NAME _____

LOCAL ADDRESS _____ HOME PHONE _____

WORK PHONE _____

PERMANENT ADDRESS _____ CELL PHONE _____

EMAIL _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

LOCAL ADDRESS _____ HOME PHONE _____

WORK PHONE _____

MEDICAL HISTORY

CHECK ALL THAT APPLY:

- | | | | |
|---|--|--|------------------------------------|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> THEATRE MINOR | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> CHRONIC BACK PAIN | <input type="checkbox"/> CHRONIC FATIGUE | <input type="checkbox"/> CARPAL TUNNEL | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> HYPOGLYCEMIA | <input type="checkbox"/> MIGRAINES |
| <input type="checkbox"/> MYTRAL VALVE
PROLAPSE | <input type="checkbox"/> PREGNANT | <input type="checkbox"/> VERTIGO | |

PLEASE LIST ANY OTHER CONDITIONS THAT MIGHT HINDER OR AFFECT YOUR PERFORMANCE:

PLEASE LIST ANY OTHER EXISTING HEALTH CONDITIONS (E.G. MUSCULAR DYSTROPHY, HIV, CANCER):

PLEASE LIST ANY MEDICATIONS YOU TAKE REGULARLY (PLEASE INCLUDE BIRTH CONTROL):

PLEASE LIST ANY MEDICATIONS YOU ARE KNOWN TO BE ALLERGIC TO:

PLEASE LIST ANY OTHER ALLERGIES YOU MAY HAVE (I.E. LATEX, SHELL FISH, BEE STINGS):

