

Reality Factor 2018 Medical Information

(For Cornerstone Use Only)

Please provide the following information in case medical treatment is necessary:

Name: _____

Allergies: _____

Medications being taken (instructions): _____

Date of last tetanus shot: _____

Physical impairments / restrictions: _____

Personal Physician:

Name: _____

Address: _____

Phone: _____

Health Insurance Coverage:

Company: _____

Policy # / Group # / ID #: _____

(Copy health insurance card and attach.)