

2nd BN 640th RTI OCS Emergency Data

Rank:
Gender:

Name: _____.

Unit: _____ City and State UNIT is in: _____.

Your Age: _____.

In case of Illness or Accident Notify- -Name: _____.

Address: _____ City: _____ State: _____.

Zip: _____ Phone:[Day]() _____ [Evening]: _____.

Medical Information (please list conditions for you safety)

List **all** Allergies:

List any medical problems (Past or Present):

Do you have a Profile: YES / NO

List any personal problems that may cause you interference with this course:

I certify the above information is complete and accurate. I understand that if I have not disclosed all information I will be dropped form the course.

Soldiers Signature: _____ Date: _____.