Range Day-Of Safety Form

(Please complete and email back to
shesapistolllc@gmail.com)

Name:					
DOB:		Insurance Coverage:			
Age:		Height:		Weight:	
Current Medications (name, dose, last use)					
Allergies	Yes/No	If yes, explain			
Do you own an epinephrine pen?		Where is it located?			
Blood Type		Eye Wear (including contact lenses)	Yes/No		
Medical Condition(s)					
Primary Care Physician Name					
Primary Care Physician Contact					
Emergency Contact: Name and Phone Number					