



New England  
School of  
Acupuncture

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Student Name: \_\_\_\_\_  
(Please Print Clearly) Last Name, First Name, MI

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

(This information may be used to contact you regarding class cancellations)

## Emergency Contact Information

In case of emergency, please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day phone: \_\_\_\_\_ hours to use this number \_\_\_\_\_

Evening phone: \_\_\_\_\_ hours to use this number \_\_\_\_\_

Cell phone: \_\_\_\_\_

Please list any allergies to medications: \_\_\_\_\_

List any health concerns/ medical history which could be of importance in a medical emergency (i.e. diabetes, etc.):

This information will be kept on file but will not be left accessible except to persons with legitimate educational purposes. If you choose not to disclose information regarding allergies or medical history, please write **not provided** on this sheet, so that health professionals will know that there may be something, and not assume that blank answers mean no allergies or health history. Thanks, for helping us help you.

Date updated: \_\_\_\_\_  
(Office Use Only)