HMHB
Annual Information Form

HEALTHY MINDS BODIES
VETERANS ★ FITNESS TRAINING ★ NETWORKING®
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Putting People First
NEDSRA
Special Recreation Association

Step 1 Veteran Information

Birthday: ___ Age: ___

Name: ___ Ethnicity: ___

Address: ___

City: ___ Zip: ___ State: ___

Email: ___

Gender: Male Female T-Shirt Size: ___ Phone 1: ___ Phone 2: ___

Service Connected Disability Percentage: ___ %

Primary Diagnosis: ___

Secondary Diagnosis: ___

Does veteran have a seizure disorder? ☐ Yes ☐ No Date of last seizure: ___ *If yes, complete Seizure Information Form

Step 2 PT Partner

Birthday: ___ Age: ___

Name: ___ Ethnicity: ___

Address: ___ Gender: Male Female

City: ___ Zip: ___ State: ___ Phone 1: ___

Email: ___ Phone 2: ___

Step 3 Emergency Contact Information

Emergency contacts should be someone other than a parent, guardian or PT Partner.

#1 Name: ___ Relationship: ___

Email: ___ Phone: ___

#2 Name: ___ Relationship: ___

Email: ___ Phone: ___

Step 4 Medication

Attach additional information if needed.

Medication Name	Dosage	Time	Purpose/Reaction

Step 5 Allergies

Attach additional information if needed.

Does veteran have allergies? ☐ Yes ☐ No

Allergy	Reaction	Additional Comments

Step 6 Dietary Restrictions

Attach additional information if needed.

Does veteran have dietary restrictions? ☐ Yes ☐ No If yes, please list ___

Step 7 Approvals

I grant photo permission for pictures to be taken and used in NEDSRA publications. ☐ Yes ☐ No

Signature: ___ Date: ___