The United Supreme Council
Ancient and Accepted Scottish Rite of Freemasonry, Prince Hall Affiliation,
Northern Jurisdiction, U.S.A., Inc.

HEALTH REVIEW FORM

CLASS OF 2026

Name: _____ Date of Birth: _____

Home Address: _____

Name of Hotel: _____ Room# _____

Primary Phone #: _____ Email: _____

Roommate (If Applicable): _____

Consistory Name and Number: _____ Orient: _____

Deputy for the Orient's Name: _____

Physician's Name: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Primary Phone: _____ Email: _____

MEDICATION AND FOOD ALLERGIES: _____

_____

CURRENT OR PAST MEDICAL CONDITIONS (*Check all that apply)*

☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Lung Disease

☐ Kidney Disease ☐ Difficulty w/Anesthesia ☐ Other: _____

Medications/Dose	How Often Taken	Medical Condition
1.		
2.		
3.		
4.		
5.		
6.		
7.		

MEDICAL FACTS: Pulse: _____/Min ☐ Regular ☐ Irregular

Resp: _____/Min BP: _____ mm Hg

DOCTOR/PHYSICIAN NOTES: _____

_____

Doctor/Physician Signature: _____ Date: _____

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