

Emergency Information Form

School / Department / Office: _____

Participant's Name: _____

Home Address: _____

Telephone: (____) _____ Age: _____ Birthdate: (mm/dd/yy) ____/____/____

EMERGENCY CONTACT(S) (Names and Phone numbers)

Name: _____

Address: _____

Relationship: _____ Home Phone (____) _____ Work Phone (____) _____

Name: _____

Address: _____

Relationship: _____ Home Phone (____) _____ Work Phone (____) _____

Personal Physician's Name: _____

Address _____ Phone(____) _____

I am taking the following medication _____

I am allergic to: _____

Prescription Eyewear Y ____ N ____

Please state any medical conditions of which emergency staff needs to be aware: _____

Do you have health insurance? _____ If yes, please provide the following:

Policy No. _____ Your Parent's / Guardian's Policy No. _____ Other _____

Name of Primary Insured _____ Policy or ID # _____

Name of Insurance Company: _____ Phone: (____) _____

Address of Company _____

Signed _____ Date: _____

Participant

(If under 18 years of age)

Signed _____ Date: _____

Parent / Guardian

One copy of this form is to be retained by the Leader for use during the event. One copy to be filed with the School / Department / Office.