EMERGENCY INFORMATION FORM

Please complete this form in its entirety. All requested is required. This information will be helpful in the unlikely event of an accident or sudden illness. (NOTE: This form is two-sided. Please fill out both sides.)

TO MAINTAIN PRIVACY, PUT COMPLETED FORM IN SEALED ENVELOPE
ENVELOPE WILL ONLY BE OPENED IN CASE OF EMERGENCY.

Participant Name: _____ Phone: _____

Participant's Address: _____
Street City State ZIP

Date of Birth: _____

Name of Personal Physician: _____ Phone: _____

Physician's Address: _____
Street City State ZIP

EMERGENCY CONTACT INFORMATION

Required:
Person(s) to be contacted in case of emergency:

Name: _____ Relationship: _____

Address: _____
Street City State ZIP

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

MEDICAL INFORMATION

Indicate medication(s) which is/are taken on a regular basis (attach a separate page if needed):
Note: Participant should bring an adequate supply of their medication(s) with them.

Name of Medication	Dosage	Prescribing Physician

Is there a medical history involving any of the following:

	Yes	*No*
Allergies		
Convulsions		
Diabetes		
Disabilities		
Epilepsy/Seizure Disorder		

	Yes	*No*
Heart Disease		
Phobias or Fears		
Past Injuries/Illnesses		
Past Operations		
Other		

If you answered "yes" for any of the above conditions, please explain in detail. *Use a separate page if necessary.*

Please explain of any special instructions, side effects or emergency procedures:

Date of Last Tetanus Booster: _____

Signature _____ Date _____