Emergency Contact and Medical Information

(to be filled out by parent or guardian)

Participant's Name: _____ Gender: male female

Participant's Address: _____ Date of Birth: _____
Street City State Zip

Participant's Phone: _____ Participant's email: _____

Mother or Guardian

Name: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Business Name: _____ Work Phone: _____

Email: _____

Signature: _____

Father or Guardian

Name: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Business Name: _____ Work Phone: _____

Email: _____

Signature: _____

If Medical Care is Necessary, Call:

DOCTOR: _____
Name Specialty City State Phone

OTHER: _____
Name Specialty City State Phone

Name of Insurance Company_____ User #: _____ Group #: _____

In case of an emergency, or if I cannot be contacted please contact the following person(s) to help track me down.

Name: _____

Relationship: _____

Address: _____
Street City State

Telephone: _____ Cell phone: _____

Name: _____

Relationship: _____

Address: _____
Street City State

Telephone: _____ Cell phone: _____

Medical Information (information about medications is contained on a separate form)

Is your child allergic to food, medicine or other substances? **Yes** **No**
(If yes, name foods, medicines or substances to be avoided and procedure to follow if reaction occurs.)

_____

_____

Are there any physical conditions that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing/sight impairment, hernia, etc.)? **Yes** **No**

_____

_____

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. I understood that I will be liable for the expense of this service.

_____
Parent or Guardian printed name Signature Date

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