Participant Emergency Information

NAME OF PARTICIPANT: _____D.O.B_____
NAME OF PARENT/GUARDIAN(S): _____

EMERGENCY CONTACT INFORMATION:
Emergency Contact Name: _____
Relationship: _____ Address: _____
Email: _____
Home phone: _____Work: _____Cell: _____

Emergency Contact Name: _____
Relationship: _____ Address: _____
Email: _____
Home phone: _____Work: _____Cell: _____

INSURANCE: (optional)
Each volunteer is responsible for medical costs. Sickness and accident insurance is **recommended but not required**.
Do you have health insurance? □ Yes □ No Does your Ins. Co. require preauthorization? • Yes • No
Insurance Company:_____ Policy#_____ Phone: _____

HEALTH/PHYSICIAN/CLINIC INFORMATION: (optional)
Physician/Clinic name: _____Phone:_____
I have the following allergies and/or medical conditions that you should be aware of in case of a medical emergency:

Other pertinent Medical Information: