

Participant's Emergency Medical Information

(Instructor will receive this information)

Participant's name: _____

Participant's gender _____ (Male = M, Female = F)

Parent's name (if different from guardian) _____

Parent's address _____ City _____ Zip _____

Mother's phone #s h _____ w _____ c _____

Father's phone #s h _____ w _____ c _____

Emergency contact _____ Relation _____

Emergency phone # h _____ w _____ c _____

Physician's name _____ Phone #s _____

Dentist name _____ Phone #s _____

Hospital preference _____

Health Insurer _____ Id # _____

Grp # _____

Dental Insurer _____ Id # _____

Grp # _____

Employer _____

Participant's special health need(s) or other special instructions

Initials _____ Date ___/___/___

Upon unsuccessful attempt to contact me, I consent to emergency medical treatment, deemed necessary by a licensed physician or dentist, at the nearest hospital emergency facility or at the hospital identified above. This consent includes immediately responding emergency medical personnel.

Parents or guardian(s) signature _____ Date ___/___/___

_____ Date ___/___/___