

Emergency Contact Form

PLEASE PRINT ALL DETAILS CLEARLY

Date: _____

BLOOD TYPE: _____

Last Name

First Name

Middle Name

Home Address: _____

City

State

Zip Code

Date of Birth

Cell Phone: Area Code ()

Home Telephone: ()

Insurance Information:

MSM

Other:

Insurance member ID:

Please list the people you would like to be notified in case of emergency, including a local contact.

IN CASE OF EMERGENCY CONTACT:

(1) Name & Relationship _____

Street Address

City

State

Zip Code

Telephone () _____ Daytime Phone # () _____

(2) Name & Relationship _____

Street Address

City

State

Zip Code

Telephone () _____ Daytime Phone # () _____

Are you allergic to anything? Yes / No _____

If yes, please list all allergies.

Are you taking any medication we should be aware of? Yes / No _____

If yes: Please list all medications we should be aware of:

Do you have any medical/mobility/mental health concerns of which we should be aware? Yes / No _____

If yes, please list medical/mobility/mental health concerns that we should be aware of: _____

The information requested on this card is confidential and for emergency use only. In the event of a medical emergency, this information will be used by authorized emergency personnel. Please be honest when completing all pertinent information.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this card may be notified in an emergency, as needed.

Signature & Date: _____ Name: _____