EMERGENCY MEDICAL INFORMATION

NOTE: All items require an entry. If you do not know or have no answer, then specify by entering "None".

Name of Volunteer:____

IN CASE OF EMERGENCY, PLEASE CONTACT:
Please provide information for someone who can make medical decisions for you if you are unable to do so. "None" is not acceptable for this part.

Name: ____

Relation: ____

Address: ____

Phone (H): ____________________ (W or C): ____________________

The following information may be needed by any hospital or medical practitioner not having access to the Volunteer's medical history:

Date of birth: ____

Allergies (medicine, food, insects, etc.): ______________________________

____

Medications being taken: ____________________________________

____

Date of last tetanus shot: ____________________________________

Physical impairments: ____________________________________

Other: ____

Primary Physician:

Name: ____

Address: ____

Phone (H): ____________________ (W): ____________________

Health Insurance Coverage:

Company Name: ____

Policy/ID Number: ____

Insurance agent: ____