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: _____