EMERGENCY MEDICAL INFORMATION

Participant Name: _____ Phone Number: _____
(Last) (First)

Participant Address: _____

Date of Birth: _____ Gender: _____

Program/Activity Name: _____

In Case of emergency, please notify:

Person 1:
Name: _____
Phone: _____
Relationship: _____

Person 2:
Name: _____
Phone: _____
Relationship: _____

Medical Information:

In the event an illness/injury or a serious medical emergency occurs, care will be provided at a local medical facility. Please provide us with the following information as well as any additional information which would be appropriate for medical professionals to know in the event of an emergency.

Doctor's Name: _____ Doctor's Phone # _____

Current Medications: _____
(If you need additional space, please use the back side)

_____

Known Allergies (drug, food, other): _____

_____

Known Conditions (asthma, other): _____

_____

Special Assistance required or any other important information: _____

_____

In the event of an illness/injury or an emergency, I authorize the above program/activity staff and/or Hillsborough Township to arrange for emergency transportation and/or emergency medical care.

_____ _____
Signature of Participant *Date*

Printed Name: _____