

HEALTH/EMERGENCY FORM

Name _____

Address _____ Birthdate _____

City/State/Zip _____ SSN _____

Home Telephone _____ Cell Telephone _____

Emergency Contact:

Name _____ Relationship _____

Home Telephone _____ Work Telephone _____

Cell Phone _____

HEALTH INFORMATION: List/check any health conditions such as heart disease, diabetes, epilepsy, severe allergies (Epi-Pen), eye or ear problems, any chronic conditions, or special needs.

Asthma _____	Medication? _____	Inhaler? _____
Life Threatening Allergies _____	Medication? _____	EpiPen? _____
Epilepsy _____	Heart Condition _____	Severe Headaches _____
Emotional Problems _____	Kidney Disorder _____	Diabetes _____
Migraines _____	Other _____	
Drug Allergies _____		

Current Medications _____

DOCTOR: Name _____ Telephone _____

INSURANCE: Carrier _____ Policy Number _____

Permission is granted to the group leaders to share this information with individuals who perform emergency medical treatment. I authorize the the group leaders to contact the person (s) named on this form and authorize the named physician to render me any emergency treatment the physician deems necessary. If physicians or other persons named on this form cannot be contacted, the Emergency Healthcare Providers may take whatever action they deem necessary for my health. I will not hold the group leaders financially responsible for the emergency care and/or transportation to a healthcare facility.

Date _____ Signature _____

ALL INFORMATION IS CONFIDENTIAL AND IS TO BE KEPT IN A SEALED ENVELOPE THEN CARRIED BY THE GROUP LEADER. THE ENVELOPE WILL ONLY BE OPENED IN THE EVENT OF AN EMERGENCY. ENVELOPES WILL BE RETURNED AFTER THE MEET UP.

