EMERGENCY CONTACT FORM

PLEASE PRINT ALL DETAILS CLEARLY

Date:

Last Name: **First Name:** **Middle Name:**

Home Address:

City: **State:** **Zip Code:** **Date of Birth:** / /

Cell Phone: ( ) **Home Telephone: ( )**

Insurance Information: **MSM** **Other:** **Insurance member ID:**

IN CASE OF EMERGENCY CONTACT:

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

1. Name and Relationship:

Home Address:

City: State: Zip Code: Date of Birth: / /

Telephone: ( ) **Daytime Phone: ( )**

2. Name and Relationship

Home Address

City: State: Zip Code: Date of Birth: / /

Telephone: ( ) **Daytime Phone: ( )**

Are you allergic to anything? Yes / No (please circle one)

If yes, please list all allergies:

Are you taking any medication we should be aware of? Yes / No (please circle one)

If yes, please list all medications we should be aware of:

Do you have any medical/mobility/mental health concerns that we should be aware of: Yes / No (please circle one)

If yes, please list all 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:**