Emergency Contact and Medical Information

Participant's Name: _____

Birth Date (mm/dd/yy): _____ Gender (circle one): male female

Home Address: _____
(street/city/state/zip)

Home Phone #: _____

Mother's name: _____ Cell phone: _____

Email address: _____ Business phone: _____

Father's name: _____ Cell phone: _____

Email address: _____ Business phone: _____

In an emergency when parent/guardian cannot be reached, please contact the following:

Name: _____ Phone-1: _____ Phone-2: _____

Name: _____ Phone-1: _____ Phone-2: _____

Please list Participant's allergies: _____

Please list other medical conditions: _____

Physician: _____ Phone: _____

Medical Insurance Company: _____ Phone: _____

Policy Holder's Name: _____ Policy #: _____

MEDICAL TREATMENT AUTHORIZATION:
I hereby give my consent to have a trainer, coach, manager, program administrator, emergency medical technical, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the participant to a medical treatment facility should it be considered to be warranted.

Name (print): _____ Date Signed (mm/dd/yy): _____

Signature: _____ Relation to Participant (check or circle one):
☐Mother ☐Father ☐Guardian