Date Completed:

_____

Emergency Form

Name: _____ _____ _____ Birth date: ____/____/____

Last Name **First Name** **M.I.**

Address: _____ Apt. #: _____

City: _____ State/Zip: _____

Home Phone: _____ Mobile Phone: _____

Social Security Number: _____ - _____ - _____ Driver's License/ State ID #:_____

Hair Color: _____ Eye Color: _____ Height: _____ Weight: _____

Emergency Contact Information

Name: _____ Relationship: _____

Mailing Address: _____

Home Phone: _____ Mobile Phone: _____

Name:_____ Relationship: _____

Mailing Address: _____

Home Phone: _____ Mobile Phone: _____

Medical Information

Primary Care Doctor: _____ **City/State:** _____
Telephone Number: _____ **Emergency Service:** _____
Specialty Doctor: _____ **City/State:** _____
Telephone Number: _____ **Emergency Service:** _____

If necessary, transport me to the following hospital: _____

Pacemaker: _____ **Yes** _____ **No** **Eyeglasses:** _____ **Yes** _____ **No** **Contact Lens:** _____ **Yes** _____

No False Teeth: _____ **Yes** _____ **No** **Birthmarks/Scars:** _____

PLEASE FILL OUT IF THIS PERSON IS UNDER AGE 18

I certify that this form is for my child, under age 18.
_____ Yes, I grant permission to treat my child in an emergency
_____ No, contact me prior to treating my child

Parent Name: _____
Emergency Telephone Number: _____

Signature: _____ Date _____

Driver Name: _____

Signature: _____ Date _____