



2025 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: _____

Health Insurance information (company and number)

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 _____