

EMERGENCY MEDICAL INFORMATION

(PLEASE PRINT)

NAME OF VOLUNTEER: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____

RELATION: _____

ADDRESS: _____

PHONE: _____ WORK _____

The following information may be needed by any hospital or medical practitioner not having access to the Volunteer's medical history:

Allergies (medicine, food, etc): _____

Current Medications: _____

Date of last Tetanus Shot: _____

Physical Impairments: _____

Other: _____

Personal Physician:

Name: _____

Address: _____

Phone: _____ Home _____

Health Insurance Coverage:

Company: _____

Policy Number: _____

Insurance Agent: _____