Emergency Contact Form

Name: _____

Date of Birth: _____

Personal Contact Info:

Home Address: _____

City, State, Zip _____

Home Telephone #: _____ Cell Phone #: _____

Email: _____

Preferred Hospital: _____

Insurance Company: _____ Insurance Policy #: _____

Medicaid Card #: _____ Medicaid Card #: _____

Allergies: _____

Emergency Contact Info:

(1) Name _____ Relationship: _____

Address _____

City, State, Zip _____

Home Telephone #: _____ Cell Phone #: _____

Work Telephone #: _____ Employer : _____

(2) Name _____ Relationship: _____

Address _____

City, State, Zip _____

Home Telephone #: _____ Cell Phone #: _____

Work Telephone #: _____ Employer : _____

Emergency Contact Form

Guardian: _____ Relationship: _____

Address: _____

City, State, Zip : _____

Home Telephone #: _____ Cell Phone _____

Work Telephone #: _____ Employer: _____

Medical Contact Info:

Doctor Name: _____ Phone #: _____

Dentist Name: _____ Phone #: _____

Other: _____ Phone #: _____

Other: _____ Phone #: _____

☐ I have voluntarily provided the above contact information and authorize _____ and its representatives to contact any of the above on my behalf in the event of an emergency.

Individual Signature: _____ Date: _____

Guardian Signature: _____ Date: _____