EMERGENCY CONTACT FORM

PLEASE PRINT ALL DETAILS CLEARLY

Date	
Last Name	
First Name	
Middle Name	
Date of Birth	

Street Address	
City, State	
Zip Code	
Cell Phone	
Home Phone	

MEDICAL INFORMATION	
Physician Name	
Practice Name	
Phone	

HEALTH INSURANCE INFORMATION	
Provider (Insurance Company Name)	
Group Number	
Member ID	
Name of Primary Insured	
Insurance Company Mailing Address	
Insurance Company Phone Number	

CRITICAL MEDICAL INFORMATION	
Blood Type	
Known Conditions	
Current Medications	
Allergies	
Preferred Hospital	

IN CASE OF EMERGENCY CONTACT (List 2 individuals)		
Name		
Relationship		
Address		
City, State, Zip		
Phone Number		

The information requested on this paper is confidential and for emergency use only. In the event of a medical emergency, this information will be used by authorized emergency personnel.

In case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this card maybe notified in an emergency, as needed.

_____ _____

Signature Date

_____ _____

Relationship (Mother of Child, Father of Child, Guardian, Self) Printed Name of Person Completing Form