EMERGENCY MEDICAL FORM

Please keep this form in a sealed envelope in your unlocked glove box to be opened in case of emergency.

Name: _____

Home phone: _____ Mobile: _____ Email: _____

Address: _____

Date of Birth: _____ Medicare Number: _____

In Case of Emergency Notify:

1. Name: _____ Relationship to You: _____

Telephone: _____Mobile:_____ E-mail: _____

2. Name: _____ Relationship to You: _____

Telephone: _____Mobile:_____ E-mail: _____

Doctor: Name: _____ Telephone: _____

Address: _____

Blood Type (if known): _____

Known allergies: (describe type and severity of reaction) **Do you carry an Epipen?** Yes/No

Allergic to	Mild/severe/anaphylactic	Reaction

Current Medications: (Include exact dosage and reason for medication)

Medication	Dosage	Reason

Current medical problems or health concerns: (ie: Epilepsy/Diabetes/Heart condition/etc)

Medical problem	Action Plan

I give permission for this form to be accessed by the trip leader and to be provided to health care personnel in the event that I require medical care.

Signature: _____ Date: _____

(If more room is required for any category, please add to back of form).