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PARTICIPANT EMERGENCY FORM

PARTICIPANT NAME	DATE OF BIRTH	EVENT / TEAM / PROGRAM	DATES	MOBILE

Home address _____

Email _____ Organization / role _____

Emergency contacts

Name	Relationship	Mobile	Alternate phone	Email

MEDICAL

Physician _____

Physician phone _____

Blood type (optional) _____

INSURANCE

Health insurer _____

Policy / member no. _____

Insurer phone _____

Allergies and dietary restrictions _____

Medical conditions responders should know _____

Medications carried _____

CONSENT

- ☐ I consent to emergency medical treatment if I am unable to consent at the time
- ☐ I consent to photographs being used by the organization (optional)
- ☐ I have read the activity information and accept the risks described
- ☐ I am over 18 (if under 18, a parent or guardian signs below)

Participant signature / date _____

Parent / guardian (if under 18) / date _____

Received by / date _____