Contact & Emergency Medical Form

Information:

Name: ____________________

Pronouns: ____________________

Permanent Address: ____________________

City, State: ____________________

Zip Code: ____________________

Cell Phone: ____________________

Email: ____________________

Date of Birth: ____________________

Driver/Vehicle Info:

Driver's License? Y N #____________

Car Make/Model: ____________________

Color: ____________________

State: __________ Plate #: __________

☐ No Local Car

Dietary Information:

Please list any food allergies:

Please list any dietary restrictions:

Health Insurance:

Carrier Name: ____________________

Group Number: ____________________

Policy Number: ____________________

Emergency Contact Information:

Name: ____________________

Address: ____________________

City, State: ____________________

Zip Code: ____________________

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

Email: ____________________

Relationship: ____________________

Health Information:

Please list any allergies (medications, fabrics, detergents, hairspray/dyes, airborne):

Please list any medications you are taking:

Please list any chronic ailments:

The information on this form is kept confidential and any physical copies will be destroyed at the end of the year.

Signature: ______________________________ Date: ______________

Guardian Signature (if under 18): ______________________________

Guardian Name: ______________________________

CONFIDENTIAL