N.12 Emergency Information Form

EMERGENCY INFORMATION FORM
[Do Not Remove Helmet Until I am Examined by a Doctor]
Date:_____

Name: _____

Address: _____ City:_____ State/Prov/Zip:_____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: ___ Social Security #: _____

Drivers License #: _____ State: _____

Employer/Phone: _____

GWRRA Member #: _____ Home Chapter/State/Prov/: _____

Chapter Contact [Name & Phone #]: _____

Emergency Contact/Name: _____

Relationship: _____ Phone/Home:_____Work: _____

Address: _____ City: _____ State/Zip: _____

Blood Type: _____ Wear Contact Lenses: Yes:_____ No: ___

Blood Pressure:_____ Wear Dentures: Yes: _____ No:____

Health Insurance:	**Vehicle Insurance:**
Company:_____	Company:_____
City/state:_____	City/state:_____
Phone:_____	Phone:_____
Policy/Group #:_____	Policy/Group #:_____

Do Not leave an emergency message on an answering machine –
Contact must be made directly to a person

Local (Home) Police Department:

Address/Phone:_____

Allergies To Medications:	**Medications Now Being Used:**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Family Doctor:	**Special Notes/Health Problems:**
Name:_____	_____
Address:_____	_____
City/State/Zip:_____	_____
Phone:_____	_____
[Attach office card if available]	_____
	_____
	_____

Sign here to authorize emergency medical treatment by a [doctor, hospital, EMT] when direct authorization cannot be given:

_____