CIWC MEDICAL INFORMATION & EMERGENCY CONTACT FORM

Club Participant:
Name (first, middle, last) _____

_____
Address & Phone (including area code)

_____
Date of Birth_____

Physician:

Name (first, middle, last): _____
Phone # (including area code):_____

Medical Conditions:

Please list any significant medical conditions (asthma, diabetes, epilepsy, etc.):

_____
_____
_____
List any allergies or allergic reactions to medications

_____
_____
List any medications you are presently taking:

_____
_____
_____
Other pertinent medical information:

_____
_____
Date of most recent tetanus shot:

_____

Medical Insurance Information:

Insurance Company

_____
Policy Number: _____ Insurance Company Phone #:_____

Emergency Contacts

First contact
Name (first, middle, last): _____
Relationship_____
Daytime Phone (including area code) _____
Evening Phone (including area code):_____
Second Contact
Name (first, middle, last): _____
Relationship_____
Phone (including area code)_____

Send a copy to your trip leader prior to trip leaving for each trip in which you wish to participate. Should the need arise this information will be given to the proper medical authorities.

_____

_____ _____
Signature Date