



EMERGENCY CONTACT FORM

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

PARTICIPANT INFORMATION _____

Complete this section for the participant, please include any relevant medical information.

NAME: _____ Member YES NO (circle one)

GENDER: _____ BIRTHDATE: _____ AGE: _____

LIST AND DIAGNOSED CONDITION(S) SUCH AS ASTHMA, ADD, SEIZURES, DIABETES, ETC.

LIST ANY KNOWN ALLERGIES INCLUDING ALLERGIES TO MEDICATIONS.

LIST ANY MEDICAL CONDITIONS THAT MAY LIMIT PARTICIPATION IN ACTIVITIES.

LIST PRESCRIPTION MEDICATIONS BEING TAKEN.

LIST ANY SPECIAL NEEDS OR RELEVANT INFO THE INSTRUCTOR SHOULD KNOW.
