

Saint Anne Catholic Community

Adult Health and Emergency Contact Information

THIS FORM MUST BE COMPLETED FOR EVERY ADULT PARTICIPATING

Adult Name _____

Event Name _____

Event Date(s) _____

MEDICAL AUTHORIZATIONS

In the event that the emergency contact listed cannot be reached, and in the judgment of the responsible adults or other appropriate staff members accompanying the group, if there is a necessity for immediate examination and/or medical treatment, I hereby authorize any of the aforesaid personnel to obtain for myself such medical services as are deemed necessary.

EMERGENCY CONTACT

Emergency Contact Name _____

Relationship _____ Phone Number _____

Physician _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Policy in the Name of _____ Insurance Company _____

Policy Number _____ ID Number _____

HEALTH INFORMATION

Allergies: _____

Current Medications _____

Additional Information _____

Printed Name _____

Signature _____ Date _____

Address _____ Telephone _____