

# St. Anne Catholic Community

## Adult (18 years or older) 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 \_\_\_\_\_

### INSURANCE INFORMATION

Policy in the Name of \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ ID Number \_\_\_\_\_

### HEALTH INFORMATION

Allergies/Dietary Restrictions: \_\_\_\_\_

Current Medications \_\_\_\_\_

Additional Information \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_