Salt 'n Light Missions

EMERGENCY MEDICAL INFORMATION

(To be filled out and submitted by all participants)

Participant's Name _____
Last First M.I. Date of Birth

Address _____

Phone _____ Email _____

Emergency Contact Person _____
Name Relationship Phone

Health Insurance Company _____

ID/Policy # _____ Group # _____

Employer (adult) _____

Parent's Name (youth) _____ Primary Care Physician _____

Are you taking any medication at present? Y N

If yes, please list: _____

Are you allergic to any medications? Y N

If yes, please list: _____

Non-prescription medications you do **NOT** want to receive: _____

Have you had a tetanus shot within the last 5 years? Y N

Do you have any other allergies (bee stings, food, etc.)? Y N
If yes, please list and describe your allergic reaction (hives, throat closes, etc.): _____
_____

Do you have current medical problems or restrictions? Y N

If so, indicate: _____

I give permission for the adult team supervisor to transport and request medical attention for my child.

_____
Signature of participant Parent Signature if participant is under 18

NOTE: The above stated insurance coverage will be applied in all situations requiring medical attention.
Please print this form on one page and return to SnL before or at time of registration.

Updated 2/2017