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