

# Emergency Contact Form

Aquehongian Lodge 112

Event: \_\_\_\_\_ Date \_\_\_\_\_

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Name of Parent/Guardian or next of kin \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Additional phone numbers (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

If person above is not available in the case of an emergency, contact (list two)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of Personal Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Personal Health/Accident Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

**In case of an emergency, I understand every effort will be made to contact me (parent, guardian or next of kin). If I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or me, if an adult).**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent's Full Name (print) \_\_\_\_\_

Signature of Parent/Guardian or adult \_\_\_\_\_

Check all items that apply, past or present, to your health history, Explain any "YES" answers.

Allergies, any and all Yes \_\_\_ No \_\_\_ List: \_\_\_\_\_

## **General Medical Information: Circle Yes or No**

**Asthma** Yes No **Diabetes** Yes No

**Cancer/ Leukemia** Yes No **Heart Trouble** Yes No

**Convulsions/Seizures** Yes No **Hemophilia** Yes No

**High Blood Pressure** Yes No **Kidney Disease** Yes No

Other (list) \_\_\_\_\_

List medications/dosage to be taken at camp \_\_\_\_\_

List any physical or behavioral conditions that may affect or limit full participation in all activities (if none, state none) \_\_\_\_\_

List equipment used by participant (such as wheel chair, braces, glasses, contact lenses, etc.) \_\_\_\_\_

Please give last immunization date of Tetanus Toxoid \_\_\_\_/\_\_\_\_/\_\_\_\_

**This form must accompany all Youths and Adults who are participating in the event!**