

**Medical Information,
Consent for Emergency Medical Treatment &
Emergency Contact Information Form**

Participant Name _____
Date of Birth _____

Medical Insurance

Is the participant covered by medical/hospital insurance? Yes No
If so, list the policy/group number:

Carrier Name _____
Name of Insured _____
Relationship of Insured to Participant _____

Medical Information

Primary Care Physician _____
Phone _____
Address _____
City, State and Zip Code _____

Does the participant have any chronic or acute medical conditions that would require any accommodation to permit participation in the program/activity? Yes No
If yes, please explain.

Please list any medications that would need to be administered to participant in case of an emergency.

Please list any allergies to medications, food, pollen, insect bites, etc. and/or other dietary restrictions, and indicate if participant carries an EpiPen for allergic reactions.

Please list any other special needs or medical issues that would be important for caregivers to know about in case of an emergency.

Participant Home Phone _____
Participant Cell Phone _____

In Case of Emergency, Please Notify

Primary Contact's Name _____
City _____
Relationship Parent Legal Guardian Sibling
 Other, describe _____
Home Phone _____ Alternate Phone _____
Email Address _____

AND/OR

Secondary Contact's Name _____

City _____

Relationship Parent Legal Guardian Sibling

Other, describe _____

Home Phone _____ Alternate Phone _____

Email Address _____

Consent for Emergency Medical Treatment

I hereby give consent to Stanford University to obtain all emergency medical care under whatever conditions are necessary to preserve the life, limb or wellbeing of the Participant named above.

Participant Signature _____

Date _____

Parent/Legal Guardian Signature

(If parent/guardian's plan covers the participant or if participant is under 18 years old at the start of the program/activity)

Signature _____

Date _____

Parent/Guardian Name Printed _____