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
Please attach a copy of the participant's medical insurance card.
Provide 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 the University of the Pacific 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

Custodial Parent/Legal Guardian Signature
(If custodial 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