



THETFORD RECREATION DEPARTMENT

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Emergency Medical Contact Information

PARTICIPANT NAME _____ Date of Birth ____/____/____
Last First MI

Home Address _____

EMERGENCY CONTACTS

Parent/Guardian #1 _____	Parent/Guardian #2 _____
Address _____	Address _____
Home Phone (____) _____	Home Phone (____) _____
Work Phone (____) _____	Work Phone (____) _____
Cell Phone (____) _____	Cell Phone (____) _____

Alternate Emergency Contact (in case parents/guardians can't be reached)

Name _____ Address _____ Relation _____
Home Phone _____ Work Phone _____ Cell phone _____

PRIMARY CARE

Physician Name _____	Phone (____) _____
Address _____	
Dentist Name _____	Phone (____) _____
Address _____	

MEDICAL INFORMATION

Allergies _____ Medications _____
Medical Conditions/ Limitations _____

INSURANCE INFORMATION

Insurance Co _____	Policy Holder _____
ID/Policy # _____	Phone (____) _____
Dental Co _____	Phone (____) _____

PERMISSION TO TREAT & RELEASE THIS EMERGENCY HEALTH INFORMATION FORM IN EMERGENCIES

I hereby give consent for the Thetford Recreation Program Coordinators, coaches or health care provider(s) considered appropriate by him/her to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment, or counseling for my son/daughter/ward. Should an emergency arise in which time is an important factor and the Thetford Recreation Program Coordinators or coaches are unable to contact me promptly, I authorize an attending physician, Thetford Recreation Program Coordinator, coaches and/or health care provider to exercise their best judgment in the interest of my child's welfare. I also give permission for this Emergency Health Information Form to be released to those Thetford Recreation Program Coordinators, coaches or appropriate health care providers who may need this information in order to treat my son/daughter/ward in a medical emergency.

Signature of Parent or Guardian _____ Date ____/____/____