EMERGENCY INFORMATION FORM
[Do Not Remove Helmet Until a Doctor examines me]

Date:_____

Name:_____

Home Phone:_____ **Work Phone:**_____

Address:_____ **City:**_____ **State/Zip:**_____

Date of Birth:_____ **Sex:**_____ **Social Security #:**_____

Drivers License #:_____ **State:**_____

Employer/Phone:_____

GWRRA Member #:_____ **Home Chapter/State:**_____

Chapter Contact [Name & Phone #]:_____

Emergency Contact/Name:_____
Relationship:_____ **Phone/Home:**_____ **Work:**_____
Address:_____ **City:**_____ **State/Zip:**_____

Health Insurance:	**Vehicle Insurance:**
Company:_____	**Company:**_____
City/State:_____	**City/State:**_____
Phone:_____	**Phone:**_____
Policy/Group #:_____	**Policy/Group #:**_____

Blood Type:_____ **Wear Contact Lenses: Yes:**_____ **No:**_____
Blood Pressure:_____ **Wear Dentures: Yes:**_____ **No:**_____

Allergies to Medications:	**Medications Now Being Used:**
1._____	**1.**_____
2._____	**2.**_____
3._____	**3.**_____
4._____	**4.**_____

Family Doctor:_____ **Special Notes/Health Problems:**
Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

(Attach office card if available)

Do not leave an emergency message on an answering machine - contact must be made directly to a person

Local Police Department:

Address/Phone:_____

Sign here to authorize emergency medical treatment by a [Hospital, Doctor, Paramedic, or EMT] when direct authorization cannot be given:_____