EMERGENCY INFORMATION FORM
[Do Not Remove Helmet Until I am Examined by a Doctor]

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:______________
Blood Pressure:______________

Wear Contact Lenses: **Yes:**______ **No:**______
Wear Dentures: **Yes:**______ **No:**______

Allergies To Medications:
1.______________
2.______________
3.______________
4.______________

Medications Now Being Used:
1.______________
2.______________
3.______________
4.______________

Family Doctor:______________
Name:______________
Address:______________
City/State/Zip:______________
Phone:______________
[attach office card if available]

Special Notes/Health Problems:
____
____
____
____

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 [doctor, hospital, EMT] when direct authorization cannot be given:______________