

Volunteer Emergency Contact and Medical Info Form

Please print and complete this form. This information will be kept confidential and used only in the event of an emergency.

Volunteer Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip Code:

Primary Emergency Contact

Contact Person Name:

Relationship to Volunteer:

Primary Phone Number:

Alternate Phone Number:

Email Address:

Secondary Emergency Contact

Contact Person Name:

Relationship to Volunteer:

Primary Phone Number:

Alternate Phone Number:

Medical Information

Allergies (Food, Medication, Environmental):

Current Medications:

Existing Medical Conditions / Physical Limitations:

Blood Type (if known):

Primary Care Physician Name:

Physician Phone Number:

Health Insurance Information

Insurance Provider Name:

Policy / Group Number:

Policy Holder Name:

Consent and Signature

I hereby authorize the sharing of this information with emergency medical personnel in the event of a medical emergency.

Volunteer Signature (or Parent/Guardian if under 18):

Date: