

# Member Emergency Contact Information Form

Please complete this form to ensure we have the most up-to-date emergency contact information on file. Please print clearly.

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## Member Information

Last Name:	<input type="text"/>	First Name:	<input type="text"/>
Date of Birth (MM/DD/YYYY):	<input type="text"/>	Member ID Number:	<input type="text"/>
Primary Phone:	<input type="text"/>	Email Address:	<input type="text"/>
Home Address:	<input type="text"/>		

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## Primary Emergency Contact

Full Name:	<input type="text"/>
Relationship to Member:	<input type="text"/>
Primary Phone:	<input type="text"/>
Secondary Phone:	<input type="text"/>
Email Address:	<input type="text"/>

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## Secondary Emergency Contact

Full Name:	<input type="text"/>
Relationship to Member:	<input type="text"/>
Primary Phone:	<input type="text"/>
Secondary Phone:	<input type="text"/>
Email Address:	<input type="text"/>

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## Medical Information (Optional)

This information will only be shared with medical professionals in the event of an emergency.

Known Allergies:	<input type="text"/>
Current Medical Conditions / Medications:	<input type="text"/>
Preferred Hospital (if applicable):	<input type="text"/>

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## Consent and Signature

I confirm that the information provided on this form is accurate. In the event of an emergency, I authorize the designated emergency contacts to be notified.

Member Signature:	<input type="text"/>	Date:	<input type="text"/>
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