Emergency contact and medical information

This form is intended to be used to assist programme and event facilitators in the case of any medical treatment required or medical emergency involving a participant

Name :
Date of Birth:
Sex:
Home Phone:
Work Phone:
Mobile Phone:
Address:

Postal Address (if different from above):

Emergency contact information

Primary Emergency Contact:
Home Phone:
Work Phone:
Address:

Secondary Emergency Contact:
Home Phone:
Work Phone:
Address:

Medical information

Hospital/Clinic Preference:
Physician's Name:
Phone Number:
Social security card number and country:
Insurance Company Name:
Insurance Company Policy Number:
Insurance Company Policy Phone:

Medical conditions:

Please tick below any relevant medical conditions you have

- ☐ **Anaphylaxis**
- ☐ **Allergies**
- ☐ **Hay fever**
- ☐ **Asthma**
- ☐ **Blood pressure**
- ☐ **Heart condition**
- ☐ **Diabetes**
- ☐ **Fainting**
- ☐ **Drug reactions**
- ☐ **Epilepsy**
- ☐ **Fits or Blackouts**
- ☐ **Sight/hearing issues**
- ☐ **Other (describe)**

For anaphylaxis, asthma, diabetes or epilepsy conditions, please provide a first aid action plan (please attach on a separate page). In the absence of a specific first aid action plan, standard first aid will be given in an emergency.

Describe what happens for any of the conditions ticked above (symptoms, severity, triggers, management, first aid action plan etc.) Please attach what cannot fit here, and your first aid action plan on a separate page:

If you take any medications, please provide further information below (name of medication, side effects, dosage, instructions for use, etc.):
Please bring any medications you require, such as an asthma inhaler, along with you

For any medical or health issues that may impact or limit your volunteering participation, not listed above, please provide detailed information (including symptoms and management if applicable):

I agree that all information contained in this document is true and correct

Name:

Date:

Signature:

Thank you.