

# Emergency Contact & Medical Information

Your Name: \_\_\_\_\_

\_\_\_\_\_  
Primary Emergency Contact Name

\_\_\_\_\_  
Secondary Emergency Contact Name

\_\_\_\_\_  
Primary Emergency Contact Relation

\_\_\_\_\_  
Secondary Emergency Contact Relation

\_\_\_\_\_  
Primary Emergency Contact Phone Number

\_\_\_\_\_  
Secondary Emergency Contact Phone Number

## Medical Information

Are you currently taking any medication? If so, please list.

\_\_\_\_\_  
\_\_\_\_\_

Have you had any surgeries within the past five years? If so, please describe.

\_\_\_\_\_  
\_\_\_\_\_

Do you have allergies to any medications? If so, please describe.

\_\_\_\_\_  
\_\_\_\_\_

Is there any other medical conditions we should be aware of?

\_\_\_\_\_  
\_\_\_\_\_

Are you currently under a physician's care? If so, please explain.

\_\_\_\_\_  
\_\_\_\_\_

- Seal this form (and only this form) in a standard envelope.
- One person's form per envelope.
- Write your full name and your team number on the envelope.
- The envelope will only be opened in the event of an emergency.