EMERGENCY CONTACT INFORMATION FORM

This information will be extremely important in the event of an accident or medical emergency.

Participant Information:

Name: ____

Date of Birth: ____________________

Address:____

Primary Emergency Contact:

Name: ____

Relationship:_____________________

Phone #:________________________ Alternate Phone #:_________________________

Secondary Emergency Contact:

Name: ____

Relationship:_____________________

Phone #:________________________ Alternate Phone #:_________________________

Insurance Information:

Company: _______________________________ Policy #: _____________________

Comments: (*Include any special medical or personal information you would want an emergency care provider to know and/or any special contact information*)

By signing below, I acknowledge that I have voluntarily provided the above information and I authorize CFBC and any of its representatives to initiate emergency medical care and to contact any of the above on my behalf in the event of an emergency.

Participant Signature:_________________________________ Date:___________________

(Parent or Guardian Signature if participant is under 18 years of age)