Emergency Contact Information Form

This information will only be used in the event of an accident or medical emergency

Name: _____
Last First MI

Phone: _____ **Cell:** _____

Email Address: _____

Address: _____
Street City State Zip Code

Primary Emergency Contact Name: _____
Last First

Relationship: _____

Phone: _____ **Cell:** _____ **Work:**_____

Secondary Emergency Contact Name: _____
Last First

Relationship: _____

Phone: _____ **Cell:** _____ **Work:** _____

Preferred Local Hospital: _____

Insurance Information:

Company: _____ **Policy #:** _____

Comments *(include any special medical or personal information you would want an emergency care provider to know – or special contact information:*

Signature: _____ **Date:** _____