



EMERGENCY CONTACT &
MEDICAL INFORMATION

NAME OF GROUP: _____

Name of Volunteer: _____

IN CASE OF AN EMERGENCY, CONTACT:

Name: _____ H Phone: _____

Address: _____ W Phone: _____

_____ Cell Phone: _____

Email: _____

Alternate contact: _____ Phone: _____

MEDICAL INFORMATION:

Allergies (medicine, food, etc): _____

Date of last tetanus shot: _____

Current Medications: _____

Physician: _____ Phone: _____

Insurance Company: _____ Policy number: _____

Insurance Phone Number: _____

Please describe below any medical or physical condition that we should know about to assure that your stay with us is healthy and safe:

PLEASE PROVIDE YOUR GROUP LEADER WITH A COPY OF THIS FORM AND
BRING A COPY WITH YOU TO THE WORK SITE/S.