Emergency Medical Information

Full Name: _____

Birthdate: _____ Signed DNR?_____

Address: _____

City: _____ State:_____ Zip: _____

In case of emergency, contact:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Name of Health Insurance Company: _____

Policy#: _____ Group#: _____

Insurance Company _____ Phone #: _____

Current Medications & Dosage: _____
_____
_____

Allergies: _____

Medical Issues: _____
_____
_____

Primary Physician: _____ Phone: _____

I, _____ (Print Name) authorize Flint River Presbytery to administer any emergency first aid treatment which might be necessary or to seek additional professional help if required on my behalf. I will not hold Flint River Presbytery or any persons acting as agents thereof, responsible for any accident, injury, or illness which might occur en route, at the destination, or on the return trip.

Signature _____ Date _____