Medical Insurance Information,
Consent for Emergency Medical Treatment &
Emergency Contact Information Form

Participant Name: _____

Medical Insurance

Is the participant covered by medical/hospital insurance? □ Yes □ No
If so, list the policy/group number: _____
Carrier Name _____ Name of Insured _____
Relationship of Insured to participant _____

Medical Information

Please list any medications that would need to be administered to participant in case of an emergency.

Please list any allergies to medications, food, insect bites, etc, and indicate if participant carries an EpiPen for allergic reactions.

Please list any other special needs or medical issues that would be important for caregivers to know about in case of an emergency.

Participant Home Phone _____ Participant Cell Phone _____

In Case of Emergency, Please Notify:

Primary Contact's Name: _____ City _____
Relationship: ☐Parent ☐Legal Guardian ☐Sibling ☐Other, describe:
Home Phone _____ Alternate Phone _____ Email Address: _____

AND/OR

Secondary Contact's Name _____ City _____
Relationship: ☐Parent ☐Legal Guardian ☐Sibling ☐Other, describe:
Home Phone _____ Alternate Phone _____ Email Address: _____

Consent for Emergency Medical Treatment

I hereby give consent to Stanford University to obtain all emergency medical care under whatever conditions are necessary to preserve the life, limb or wellbeing of the Participant named above.

Participant Signature _____ Date: _____

Parent/Legal Guardian Signature (if parent/guardian's plan covers the participant or if participant is under 18 years old at the start of the program/activity)

Signature _____ **Date:**
_____

Parent/Guardian Name Printed _____