HEARTS LANDING
RANCH

EMERGENCY CONTACT FORM

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL # _____ HOME # _____

PLACE OF EMPLOYMENT/SCHOOL: _____

PHONE # _____ CONTACT NAME: _____

EMERGENCY CONTACT'S NAME: _____

Relation: _____ Phone # _____

SECONDARY CONTACT'S NAME: _____

Relation: _____ Phone # _____

BEST NUMBER TO CALL FOR SCHEDULE CHANGES: _____

DOCTOR: _____

ADDRESS: _____ PHONE # _____

HAVE PERMISSION TO CALL EMERGENCY SERVICE/GO TO HOSPITAL?
YES_____NO_____

KNOWN HEALTH ISSUES THAT MIGHT AFFECT YOUR PARTICIPATION? _____

_____

ALLERGIES: YES _____ NO _____ IF SO, PLEASE LIST: _____

_____

EPIPEN USE? YES_____NO_____IF SO, IT IS YOUR RESPONSIBILITY TO HAVE ONE AVAILABLE WHILE ON THE PROPERTY.

LIST PRESCRIPTIONS YOU ARE CURRENTLY TAKING:

RX: _____ Condition: _____ First Started: _____

RX: _____ Condition: _____ First Started: _____

RX: _____ Condition: _____ First Started: _____

Please attach a copy of your Medical Insurance Card.