Emergency Contact and Medical Information Form

PARTICIPANT INFORMATION

Participant's Name _____ Date of Birth* _____ Gender _____

Address _____ Phone ( )_____

City, State, Zip _____ E-mail _____

Are you allergic to any medications? _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact:

Name _____

Relation to Participant _____

Daytime Phone ( ) _____

Evening Phone ( ) _____

Alternate Contact (OPTIONAL):

Name _____

Relation to Participant _____

Daytime Phone ( ) _____

Evening Phone ( ) _____

INSURANCE POLICY INFORMATION

❒ Yes The above-named participant is covered by health insurance.

❒ No **If no**, initial this line stating that you do not have health insurance and are aware that Iowa State University does not carry any health insurance for you. _____

MEDICAL EMERGENCY PERMISSION

If an injury or other medical condition occurs or arises, I hereby give permission to an ISU representative to provide routine first aid and to seek emergency treatment including X-rays or routine tests. In an emergency situation, I give permission for an ISU representative to contact the individual(s) that I have listed under Medical Emergency Contact Information. I agree to the release of any record necessary for treatment, referral, billing or insurance purposes. I understand that I am financially responsible for charges to the attending physicians or health care unit. In the event of an emergency where I cannot decide for myself, I give permission to the physician/hospital selected by the ISU representative to secure and administer treatment for me, including hospitalization.

_____ _____

PARTICIPANT SIGNATURE **DATE**

Participants under the age of 18 are required to have a parent or guardian signature

_____ _____

PARENT OR GUARDIAN SIGNATURE **DATE**

***When participants are under the age of 18, this letter must be retained until the participant is 20 years of age**