



# Emergency Information & Contacts for Minor

**DEPARTMENT & ACTIVITY**

Department \_\_\_\_\_

Class/Activity \_\_\_\_\_

**NAME OF MINOR**

Name of Minor: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**EMERGENCY CONTACT**

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**NAME OF PARENTS**

Father's Name or Guardian (if different than above): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name or Guardian (if different than above): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**NAME OF PHYSICIAN**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State, Zip Code: \_\_\_\_\_

**NAME OF INSURANCE COMPANY**

Name of Medical Insurance Provider : \_\_\_\_\_

Policy No: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

IMPORTANT: ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD

**SPECIAL CONDITIONS**

If your child has a medical problem or is taking medication that would be important for us to be aware of, please indicate here

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF PARENT/GUARDIAN**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_