BOLT Student Leadership Program

Emergency Contact / Medical Form

Participant's Name: _____ Birthdate: _____

Participant Contact Info

Phone: Home: _____ Cell: _____

E-mail Address: _____

Home Address: _____

Parent/Guardian Name(s): _____

Phone: Home _____ Work_____ Cell _____

E-mail Address: _____

Home Address: _____

Emergency Contacts

Contact #1: _____ Relationship: _____

Telephone Numbers: Home: _____ Cell:_____

Contact #2: _____ Relationship: _____

Telephone Numbers: Home: _____ Cell: _____

Participant's Usual Source of Medical Care

Physician's Name: _____ Phone #:_____

Hospital to take participant in case of an emergency: _____

Participant's Health Insurance

Name of Insurance Plan: _____

Certificate Number (or ID) #: _____ Group #: _____

Policy Holder's Name: _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:

_____

_____

Consent and Agreement for Emergencies

I give consent for the participant to receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance.

Date: _____ Parent/Guardian (*please print*): _____

Parent/Guardian Signature _____