



# Forte Fencing Club

## Emergency Contact Information

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Emergency Contacts:

Primary: \_\_\_\_\_ Phone: \_\_\_\_\_

Backup: \_\_\_\_\_ Phone: \_\_\_\_\_

### Doctor(s), Hospital, Insurance:

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Vital Medical Information:

Medications (include dosage): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

### CONSENT AND AUTHORIZATION:

I certify that that the information on this form is accurate and complete to the best of my knowledge and I agree to notify Forte Fencing Club of any changes. Should the need arise, I authorize that the information on this form should be released to the proper medical authorities so medical treatment can be administered. I understand that Forte Fencing Club will protect this information and will take every reasonable precaution to secure it from unauthorized individuals.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_