# LUTHERAN PIONEERS

## EMERGENCY CONTACT INFORMATION FORM

Particiants' Name and Grade _____ Date of Birth_____

Home Address_____ Home Phone_____

Name of Father or Legal Guardian_____

Place of Employment_____ Phone Number _____

Name of Mother_____

Place of Employment_____ Phone Number_____

Family Physician_____ Phone Number_____

***Emergency treatment consent & contact***

If there is an emergency and we cannot reach you, the parents or legal guardian, by phone; do we have your permission to call your family physician or the local emergency medical personnel? _____Yes _____No

Do we have permission to request emergency medical treatment for your minor child if you cannot be reached? _____Yes _____No

Whom shall we notify if we are unable to reach the father, mother, legal guardian, or family physician?

Name_____ Relationship to Participant_____

Address_____ Phone Number _____

***Medical information***

Please list any medical insurance information that you feel might be helpful in the event of an emergency.

Company_____ Group_____ Policy # _____

Please list any special requests you wish to make that would help us aid your child in case of an emergency:

_____

_____

**Medications Needed or Used**

| Kind | Frequency | Dosage | Currently Being Given? | |
|---|---|---|---|---|
| | | | Yes | No |
| | | | Yes | No |
| | | | Yes | No |

Special conditions to be watched for such as Allergy (reaction to food, penicillin or other drugs), fainting, sleep walking, etc. _____

Should the participant's activity be restricted because of any physical defect or illness: _____Yes _____No

If yes, explain degree of restriction _____

**PARENTAL CERTIFICATION**

*(For participants under 18 years of age)*

This form must be signed by a parent or guardian and given to the Lutheran Pioneer leader.

I _____, the parent or guardian of my minor child _____,

declare that the information given above is correct and authorize and delegate to the leaders of Lutheran Pioneer Train 95, permission to act for me with full power to obtain medical treatment, including surgery, either by a physician or at a hospital for and to incur expenses for such treatment for which I agree to assume full financial liability.

Signed _____

Relationship _____

Dated _____

PARENT/ GUARDIAN'S CONTACT INFORMATION:

1) NAME: _____

HOME PHONE: _____

MOBILE PHONE: _____

EMAIL: _____

2) NAME: _____

HOME PHONE: _____

MOBILE PHONE: _____

EMAIL: _____