Emergency Medical Form- Four Wheel Drive Club Emergency Medical Data

One form required for each occupant of every vehicle. Store in glove box.

Personal Information	Date when form was completed or updated: _____

Name: _____

Address: _____

_____

City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Date of Birth: _____ Driver's License Number: _____ State: _____

Passport Number: _____ Country: _____ *(Foreign guests only)*

Primary person to be notified in case of an emergency

Name: _____

Address: _____

_____

City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Secondary person to be to be notified in case of an emergency (Must not be occupant in vehicle)

Name: _____

Address: _____

_____

City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Physician Or Primary Medical Provider

Name: _____ Phone Number: (_____) _____

Insurance Information

Provider: _____ Policy/Group Number: _____

Contact person: _____ Phone: (_____) _____

Do you have any allergies (ex: medications, foods, environmental, animals)? No ☐ Yes ☐
If yes, provide details:
Do you have any medical conditions that affect you currently or in the recent past? No ☐ Yes ☐
If yes, provide details:
Are you taking any medications on a routine basis? No ☐ Yes ☐
If yes, provide details:
Any other information that emergency personnel should be aware of? No ☐ Yes ☐
If yes, provide details: Blood Type: _____

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by _____ and emergency personnel.

Please ensure that the form has the most updated and accurate information.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree any of my emergency contacts listed on this form may be notified in an emergency, as needed.

Signature: _____ Date: _____