



EMERGENCY CONTACT INFORMATION

PARTICIPANT INFORMATION				
Name (Last, First Middle)				
Date of Birth	Age	Sex	Home Phone #	Cell Phone #
Home Mailing Address (Street, City, State, Zip Code)				

EMERGENCY CONTACT INFORMATION - PRIMARY		
Name	Relationship	
Address (Street, City, State, Zip Code)		
Home phone #	Work phone #	Cell phone #

EMERGENCY CONTACT INFORMATION - SECONDARY		
Name	Relationship	
Address (Street, City, State, Zip Code)		
Home phone #	Work phone #	Cell phone #

MEDICAL HISTORY	
Allergy / Medical Condition - List any allergies or medical conditions (ie: bee stings, asthma, diabetes)	Emergency Treatment - List any emergency medical treatment needed to assist you if necessary

CURRENT MEDICATIONS

INSURANCE INFORMATION		
Insured by	Policy #	Group #
Subscriber's Name		

Participant acknowledgement of accuracy and understanding. By signing this form, I am declaring that, to the best of my knowledge I have completed this form accurately. I also understand that by knowingly filling out the form inaccurately, or by withholding pertinent information about my health, I could potentially be increasing the risk to myself or others.

Consent to accept aid. By signing this form, I am giving consent and permission for NPS staff or volunteers to provide medical care to me or my child, to transport me or my child to a medical facility or to seek the aid of emergency medical service as deemed appropriate. I further authorize NPS staff or volunteers to render whatever treatment they consider necessary for my or my child's health.

Participant's Name (printed)

Participant's Signature

Date

Parent/Guardian Signature (if participant is under 18)