EMERGENCY MEDICAL INFORMATION

NAME: ____

DATE OF BIRTH: ____

PARENT/GUARDIAN (if under 18 years of age):

____

ADDRESS: ____

CITY: __________________ POSTAL CODE: ______________________________

CONTACT NAME: ____

TELEPHONE NUMBER: ( ) ____

ALTERNATE CONTACT NAME: ____

TELEPHONE NUMBER: ( ) ____

PHYSICIAN'S NAME: ____

TELEPHONE NUMBER: ( ) ____

HEALTH CARD NUMBER: ____

Please list all pertinent medical information (allergies, medications being taken or medical conditions):

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