FRESNO STATE
Club Sports

EMERGENCY INFORMATION FORM

Participant's Name: _____

Team: _____ SID#: _____

Home Address: _____

Telephone: _____ Age: _____ DOB: _____

EMERGENCY CONTACT(S)

Name: _____ Address: _____

Relationship: _____ Home Phone #: _____ Work Phone #: _____

Name: _____ Address: _____

Relationship: _____ Home Phone #: _____ Work Phone #: _____

Personal Physician's Name: _____

Address: _____ Phone#: _____

I am presently under the following medication: _____

I am allergic to the following medication: _____

Presently wear contact lenses: Yes No Presently wears glasses: Yes No

Please state any medical conditions that emergency care providers need to be aware of:

_____

_____

Health insurance: **Yes** **No** Policy #: _____

Name of Insured (if different from self): _____ Relationship: _____

Name of Company: _____ Telephone #: _____

Address of Company: _____

If I need medical treatment arising out of my participation in this activity, I give my consent for the university to release the information on this form to any medical professional.

Signed: _____ Date: _____
Signature of participant, or parent or legal guardian, if participant is a minor.