

**EMMAUS OF SOUTHEAST MICHIGAN MEDICAL EMERGENCY
INFORMATION**

PLEASE PRINT LEGIBLY:

NAME: _____

EMERGENCY CONTACT: _____

EMERGENCY PHONE NUMBER: _____

RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____

PHONE (HOME) _____

(CELL) _____ (WORK) _____

DATE OF BIRTH: _____

DOCTOR'S NAME: _____

DR'S PHONE: _____

INSURANCE CO. _____

INSURANCE POLICY NUMBER: _____

KNOWN MEDICAL CONDITIONS: _____

MEDICATIONS: _____

ALLERGIES: _____

In the event I suffer a medical emergency and I am rendered unable to authorize medical treatment for myself while at the "Walk to Emmaus", I hereby authorize "Walk to Emmaus" to call 911 or other medical emergency services on my behalf and/or transport me to a medical center or hospital. I also authorize any qualified medical person, including but not limited to a paramedic, nurse, or physician to provide and perform any and all medical treatment, which is necessary for my well being.

Signature _____

Date _____

Emergency Contact: _____

Name: _____

Phone: _____