

EMERGENCY INFORMATION FORM
[Do Not Remove Helmet Until I am Examined by a Doctor]

Date: _____

Name: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State/Zip: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Drivers License #: _____ State: _____

Employer/Phone: _____

HOG Member #: _____ Home Chapter/State: _____

Chapter Contact [Name & Phone #: _____

Emergency Contact/Name: _____

Relationship: _____ Phone/Home: _____ Work: _____

Address: _____ City: _____ State/Zip: _____

Health Insurance:	Vehicle Insurance:
Company: _____	Company: _____
City/state: _____	City/state: _____
Phone: _____	Phone: _____
Policy/Group #: _____	Policy/Group #: _____

Blood Type: _____ Wear Contact Lenses: Yes: _____ No: _____
Blood Pressure: _____ Wear Dentures: Yes: _____ No: _____

Allergies To Medications:	Medications Now Being Used:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Family Doctor: _____ Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ [attach office card if available]	Special Notes/Health Problems: _____ _____ _____
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Do Not leave an emergency message on an answering machine - contact must be made directly to a person

Local Police Department:

Address/Phone: _____

Sign here to authorize emergency medical treatment by a [doctor, hospital, EMT] when direct authorization cannot be given: _____