



## Emergency Contact and Medical Information

Volunteer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Alternative Emergency Contacts

Primary Emergency Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Medical Information

Hospital/Clinic Preference: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Allergies/Special Health Considerations: \_\_\_\_\_

I have voluntarily provided the above contact information and authorize the Eagan Resource Center and its representative to contact any of the above on my behalf in the event of an emergency.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_