Emergency Contact Form
Adult Participant

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, I am in good health and I assume all responsibility for my health.

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to be transported to a hospital for emergency medical or surgical treatment. In the event of an emergency, contact:

Name: _____

Relationship to participant: _____ Phone: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Specific Medical Information: The parish and/or Diocese of Honolulu will take reasonable care to see that the following information will be held in confidence.

Medications: I am taking the following medication(s) at present:

_____

_____

Allergic reactions (medications, foods, plants, insects, etc.): _____

Any special medical conditions the staff should be aware of:

_____

_____

Signature: _____ Date: _____