Volunteer Emergency Medical Information Form

BikeMaine asks for the following basic medical information to be provided so that we can pass it on to emergency medical personnel in the event that you face a medical emergency. It is your responsibility to carry on you at all times the medical information you and your physician deem necessary for medical personnel to know when treating you for a medical emergency.

Name: _____

Address: _____

Phone #: (_____)_____ Email: _____

Date of Birth: _____

Health Insurance Information:

Insurer Name and Address: _____

Insurer Phone # (_____)_____ Policy #: _____

Group #: _____ Name of Insured: _____

Primary Care Physician:

Name: _____ Office Phone #: _____

Person(s) to Notify in Case of Emergency:
In listing these names, I am consenting to having the people listed be notified in the event I have a medical emergency.

NAME:	*RELATIONSHIP*	*HOME PHONE:*	*MOBILE PHONE:*	*WORK PHONE:*

Medical Information:

List any medication to which you are known to be allergic:

List any other allergies you are known to have (food, plants, insects):

Nature of reaction:

Will you be carrying an EpiPen with you during BikeMaine? ___Yes ___No

If yes, where will the EpiPen be located? _____

List any current medical conditions you have or for which you are being treated that you wish disclosed to emergency medical personnel in the event of your medical emergency:

List any prescriptions or medications you currently are taking that you wish disclosed to emergency personnel in the event of your medical emergency:

I hereby authorize release of this information by BikeMaine in the event of a medical emergency. In the event of an emergency where I am unable to consent to treatment, I hereby consent to such treatment.

Signature: _____ **Date:** _____