International Order Of The Rainbow For Girls in Pennsylvania
Emergency Contact and Medical Information Form

Name____ Birth Date_____________

Address____

Spouse or_________________________________ Home Number:_______________________
Other Family Member

Address____

Cell Number____________________________ Work Number __________________________

Emergency Contact Other Than Spouse ____
Or Family Member listed above

Phone Number(s) ____

Physician Name ___________________________________ Contact Number _____________

Health Insurance Provider ____

Policy Number ____

Name of Insured ____

Please list any allergies, medical concerns, or disabilities we need to be aware of:

Please list any daily medications:

By signing below, I authorize emergency medical care procedures to be administered.

____ _________________________

Signature Date