



Collegiate Challenge Emergency contact information

Complete this entire form and return it to your team leader.

1 PARTICIPANT INFORMATION

Full name _____

Allergies (medicine, food, etc.) _____

Any special dietary needs _____

List any medication being taken _____

Date of last tetanus shot _____

Physical impairments _____

Other _____

Family physician _____

Address _____

City _____ State _____ ZIP/postal code _____

Phone () _____

Name of insurance carrier _____

Phone number of insurance carrier () _____ Policy number _____

2 IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Address _____

City _____ State _____ ZIP/postal code _____

Daytime phone () _____ Evening phone () _____ Cell () _____

