

OES Snowboarding Team Emergency Contact Information Form

Please print in ink and complete all lines

Student Name: _____ Grade: _____

Home Phone: _____ Cell Phone: _____

Address: _____ Zip: _____

Email: _____

Parent/Guardian #1 Name: _____

Phone # (h) _____ (w) _____ (c) _____

Email: _____

Parent/Guardian #2 Name: _____

Phone # (h) _____ (w) _____ (c) _____

Email: _____

Emergency Contacts: (Other than the parents listed above)

Name: _____

Phone # (h) _____ (w) _____ (c) _____

Name: _____

Phone # (h) _____ (w) _____ (c) _____

Name: _____

Phone # (h) _____ (w) _____ (c) _____

Health/Accident Insurance Company: _____

Plan No: _____ Group No: _____

Member/Subscriber Name & ID Number: _____

Doctor Name: _____ Dr. Phone: _____

Preferred Hospital: _____ Date of Last Tetanus Shot: _____

Allergies: Food Medication Other (explain) _____

Other Conditions: Asthma Diabetes Convulsions Fainting Spells

Heart trouble Dentures Contact Lenses Bleeding disorders

Other (explain) _____

I consent to emergency medical treatment for my son/daughter:

Parent/Guardian Signature: _____

Parent/Guardian Name: _____ Date: _____

A copy of this form will also be filed at Mt. Hood Meadows Emergency Clinic