Emergency Medical Information Form

Any veteran participating in the Winter City Winter Sports Clinic is required to fill out the emergency medical information form. This form will only be used in an emergency situation and all information will be kept confidential

_____ (Athlete's Initials) In the event of a medical emergency during WCWSC, except for those occurring during over third-party video and audio-conferencing platforms, I hereby authorize and give my consent to the Chicago Park District and its employees, volunteers and/or partnering organization to secure from any accredited hospital, clinic, and/or physician any treatment deemed necessary for me. I agree that I shall remain responsible for any and all expenses incurred for such emergency medical care and treatment.

PERSONAL INFORMATION					
First Name:	Middle Initial:	Last Name:			
Street Address:		City:	State:	Zip:	
	(Example 1234 N. Valor St. Apt. G)				
Primary Phone Number:					
E-Mail Address:					
Date of Birth:	/ /	Gender:	Female	Male	
	Month Day Year				
Emergency Contact Name 1:					
Emergency Contact Phone Number:					
Relationship to Athlete:					
Emergency Contact Name 2:					
Emergency Contact Phone Number:					
Relationship to Athlete:					

MEDICAL INFORMATION		
Do you have any dietary restrictions and/or food allergies?	Yes	No
If yes, list allergies below:		
Are you allergic to any medications or have any other allergies?	Yes	No
If yes, list your allergies below:		
Provide a list of any medications (prescription and non-prescription) you are currently take:		
Do you require an EpiPen to treat any allergy?	Yes	No
Please describe any past or present medical conditions:		
Have you ever been diagnosed with a seizure disorder?	Yes	No
When was your last seizure?	(Month/Year)	