SOAC Inc. Participant Medical Information Form

The information contained in this form is strictly confidential and is for the official use of SOAC Inc. It remains sealed with access only to the staff of SOAC Inc. otr in the case of medical emergency, to the medical personnel involved.

Participant Name_____

Address_____City_____State_____Zip_____

Phone_____

Emergency contact Name:_____Relationship_____

Phone Day_____Evening_____Other_____

Additional Emergency contact Name_____Relsationship_____

Phone Day:_____Evening_____Other_____

Medical Insurance Information:

Company_____Policy Number_____

Medications Currently Taking: (if none, so state)_____

Reason_____

Medications taken within six months: (if none, so state)_____

Reason_____

Allergies: (if none, so state)_____

Physical Concerns or limitations: (if none, so state)_____

As the legal parent or guardian of the above listed participant, I hereby authorize emergency medical transp;portation and treatment required.

_____ _____

Parent/guardian printed Name Parent Signature Date