

BOLT Student Leadership Program  
**Emergency Contact / Medical Form**

Participant's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Participant Contact Info**

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

**Parent/Guardian Name(s):** \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

**Emergency Contacts**

**Contact #1:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**Contact #2:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**Participant's Usual Source of Medical Care**

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital to take participant in case of an emergency: \_\_\_\_\_

**Participant's Health Insurance**

Name of Insurance Plan: \_\_\_\_\_

Certificate Number (or ID) #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:

\_\_\_\_\_  
\_\_\_\_\_

**Consent and Agreement for Emergencies**

I give consent for the participant to receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance.

Date: \_\_\_\_\_ Parent/Guardian (*please print*): \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_