Garden Island Canoe Racing Association

EMERGENCY CONTACT FORM

THIS FORM MUST BE TURNED IN WHEN YOU REGISTER

Medical Insurance Coverage: ____HMSA ____KAISER ____HMA OTHER__________________ Hospital:

_______________________: _____________________________________**Physician's Name**

PARTICIPANTS NAME: _______________________________________ **DOB:** _____________ Street Address:

____ (Apt. #): ___________ City: ____________________________

State: _____________ Zip Code: ___________ Home Phone #:___________________ Work #: ___________________

Cell #:______________

IN CASE OF EMERGENCY, PLEASE CONTACT:

1) **Name:** ____ **Relationship:** ____________________ Apt. #):

____________ Street Address: ____ (City:

_________________________ State: ______________ Zip Code: ____________ Home #: ____________________

Work #: __________________ Cell #: _________________

2) **Name:** ____ **Relationship:** _________________ Street Address:

____ (Apt. #): _____________ City: ________________________ State:

_____________ Zip Code: _____________ Home #: ____________________Work #: ___________________Cell #:

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