

# N.12 Emergency Information Form



## GOLD WING ROAD RIDERS ASSOCIATION



### RIDER EDUCATION PROGRAM Emergency Information Form

[Do Not Remove Helmet Until I am Examined by a Doctor]

Date: \_\_\_\_\_

Name: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_

Employer/Phone: \_\_\_\_\_

GWRRA Member #: \_\_\_\_\_ Home Chapter/State: \_\_\_\_\_

Chapter Contact [Name & Phone #: \_\_\_\_\_

Emergency Contact/Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone/Home: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Do Not leave an emergency message on an answering machine - contact must be made directly to a person

Health Insurance: \_\_\_\_\_ Company: \_\_\_\_\_  
Vehicle Insurance: \_\_\_\_\_ Company: \_\_\_\_\_

City/state: \_\_\_\_\_ City/state: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Allergies To Medications: \_\_\_\_\_ Medications Now Being Used: \_\_\_\_\_

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |

Blood Type: \_\_\_\_\_ Wear Contact Lenses: Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Blood Pressure: \_\_\_\_\_ Wear Dentures: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
[attach office card if available]

Special Notes/Health Problems:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Local Police Department:

Address/Phone: \_\_\_\_\_

Sign here to authorize emergency medical treatment by a [doctor, hospital, EMT] when direct authorization cannot be given: \_\_\_\_\_