

# Denville Recreation Emergency Medical Information

Name \_\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

In the event of an injury, the local Rescue Squad will transport the injured person to the nearest hospital.

In case of an **EMERGENCY** when you cannot be reached, who should be notified?

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Other Phone \_\_\_\_\_
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

If there has been a custody decision please list the name or names of the person **NOT** permitted to pick up the child.

(Please provide documentation, which will be kept confidential)

Before engaging in any physical activity it is advisable to check with a physician regarding any conditions that may limit participation. Should an **emergency** arise, we need to know the following information:

Name of Physician \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Date of last Tetanus shot \_\_\_\_\_

Circle if you have any of the following:

Allergies	Specific Food Allergies	Insect Allergies	Medication Allergies
Diabetes	Seizures	Contact Lenses	Dentures

Explain in detail any circled above:

Do you carry an epinephrine pen/kit?  Yes  No

Can you self-administer the epinephrine pen?  Yes  No

Is there anything else about your health you would like us to know in case of an emergency?

Presently taking any medications?  Yes  No If Yes, what? \_\_\_\_\_

This medical history is correct and complete to the best of my knowledge.

Signature of Participant (or parent/guardian) \_\_\_\_\_ Please PRINT Signature Name \_\_\_\_\_ Date \_\_\_\_\_

Please Return To:  
Denville Recreation Department  
1 St. Mary's Place ♦ Denville ♦ New Jersey 07834  
973 625-8300 x238 ♦ 973 627-2709 Fax

Revised 03/2008