



## EMERGENCY MEDICAL INFORMATION

Members Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

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

Certification: Agency: \_\_\_\_\_ Level: \_\_\_\_\_

Number: \_\_\_\_\_ Date of Cert.: \_\_\_\_\_

Number of Logged Divers: \_\_\_\_\_ Last Dive Date: \_\_\_\_\_

In the event of an emergency, who should be contacted (in order of priority)

	NAME	Cell Phone #	Alt phone #	Relationship
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_

List any Allergies, Serious illnesses, Injuries or conditions:

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

Blood Type: \_\_\_\_\_ Hospitalization Insurance Carrier: \_\_\_\_\_

DAN Member: Y / N      DAN Insurance: Y / N

Member #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Members Signature: \_\_\_\_\_ Date: \_\_\_\_\_

COMMENTS: