



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: