

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

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

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

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

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

[attach office card if available]

Local Police Department:

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

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