Galena Ridge
Wilderness Program

MEDICAL INFORMATION

IN CASE OF EMERGENCY NOTIFY:

Name _____
First Middle Last

Relationship to Participant _____

Home Address _____
Street City State Zip

Business Telephone (____) _____ Home Telephone (____) _____

Name _____
First Middle Last

Relationship to Participant _____

Home Address _____
Street City State Zip

Business Telephone (____) _____ Home Telephone (____) _____

MEDICAL INSURANCE:

Insurance Company _____

Policyholder _____ Employer _____

Policy # _____ Subscriber # _____

Pharmacy Card _____

CONSENT FOR EMERGENCY MEDICAL CARE

In the event medical treatment is needed and Parent/Guardian is not available to make decisions or arrangements for such medical care for _____, I authorize the staff of **Galena Ridge** to provide or arrange for medical care at their discretion.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date