EMERGENCY CONTACT INFORMATION/MEDICAL INFORMATION FORM

Your Name: _____

Emergency Contact 1:

Name: _____

_____

Address _____

_____

Home: _____

Cell: _____

Email: _____

Emergency Contact 2:

Name: _____

Relationship to you: _____

Address _____

_____

Home: _____

Cell: _____

Email: _____

Please include any other relevant information here:

_____

_____

Permission for Medical Treatment *(this information remains confidential)*

I hereby give permission to the medical personnel selected by a member of the University of Washington-Kenya collaborative research and training team to secure medical evaluation and any treatment necessary to preserve life and bodily function unless exceptions are noted below:

Exceptions (if none, write none): _____

I am allergic to the following medications (response optional): _____

_____

Other medical conditions about which those providing treatment should be aware (response optional): _____

_____

_____

Signature: _____

Date: _____