

EMERGENCY RIDER/CO-RIDER INFORMATION

CIRCLE ONE

PRINT FULL NAME _____

DO NOT REMOVE HELMET UNTIL I AM EXAMINED BY A DOCTOR OR EMT

HOME # (_____) _____ CELL # (_____) _____

BIRTHDATE ___/___/___ CITY _____ STATE _____

PLEASE GIVE INFORMATION OF MY CONDITION TO MY CHAPTER MEMBERS Y / N
YOU MAY GIVE DETAILED INFORMATION TO MY EMERGENCY CONTACTS ABOUT MY CONDITION Y / N

EMERGENCY CONTACT #1

NAME _____ #(_____) _____

RELATIONSHIP _____ THIS PERSON SHOULD NOT BE A CO-RIDER

EMERGENCY CONTACT # 2

NAME _____ #(_____) _____

RELATIONSHIP _____ THIS PERSON MIGHT BE A CO-RIDER YES / NO

MD _____ #(_____) _____

HEALTH INSURANCE

COMPANY _____ #(_____) _____

VEHICLE INSURANCE

COMPANY _____ #(_____) _____

PREFERRED LOCAL

HOSPITAL _____

CITY _____ STATE _____

MEDICATION ALLERGIES Y / N FOOD ALLERGIES Y / N HX OF ANAPHALAXIS Y / N

HX HEART CONDITIONS Y / N

LUNG/ RESPIRATORY CONDITIONS Y / N

RENAL CONDITIONS Y / N

ARTIFICIAL APPLIANCES, HARDWARE , SCREWS Y / N

HISTORY OF CANCER Y / N SURGERIES Y / N

HISTORY OF DIABETES Y / N ORAL MEDS _____ INSULIN DEPENDENT _____

I HAVE A LIVING WILL Y / N I AM AN ORGAN DONOR Y / N

I WEAR DENTURES YES / NO CONTACTS YES / NO

(PLEASE LIST DETAILS TO YES QUESTIONS ON BACK OF FORM)

MEDICATIONS (MED, DOSE, FREQUENCY)

SIGN HERE TO AUTHORIZE EMERGENCY MEDICAL TREATMENT WHEN DIRECT AUTHORIZTION CANNOT BE GIVEN

SIGNATURE _____ DATE _____