Huakaʻi Aotearoa
February 17 - 25, 2025

Emergency Contact and Medical Information Form

Each participant must complete an Emergency Medical Form. The information on this form will be kept confidential and used only in emergency situations.

Instructions: Please complete all sections. Failure to complete this form will result in the inability to travel with Huliauapaʻa.

PARTICIPANT INFORMATION

Name: ________________________

Date of Birth: __________________

Email address: _________________

Mailing address: ____

City/State/Zip: __________________________

Physical address: ____

City/State/Zip: __________________________

Phone number(s): _______________

EMERGENCY CONTACT INFORMATION

Name: _________________________

Relationship: _______________

Phone number(s):

Home: ______________ Work: ________________

Cell: _______________

Name: _________________________

Relationship: _______________

Phone number(s):

Home: ______________ Work: ________________

Cell: _______________

FAMILY PHYSICIAN INFORMATION

Physician Name: ___________________

Phone: __________________________

Address: _________________________

City/State/Zip: ____________________

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INSURANCE INFORMATION

Name of insured: _______________________________

Relationship to person insured: _______________

Insurance Company Name: ______________________

Phone Number: _________________

Medical/Policy #: ________________

Group #: _______________________

MEDICAL HISTORY

Medical history if any (e.g. asthma, diabetes, heart condition, etc.):

____

____

Do you have any dietary restrictions and/or allergies (e.g. food, medicine, insects)? Yes No

If YES, please specify below:

____

____

Are you taking any medications? Yes No

If YES, please specify below:

Medical condition: ____________

Drug name: __________________

Dosage: _____________________

Frequency: ___________________

Do you self-medicate? Yes No

If YES, please provide a complete understanding of all procedures involved, and if assistance is needed.

____

____

Are all immunizations current? Yes No

Have you experienced any past medical conditions or injuries? Yes No

If YES, please specify below:

____

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____

Any Current Physical Limitations:

____

CERTIFICATIONS (*Check all that apply*)

First Aid/CPR First Responder

Lifeguard/Water Safety Other: ________________

I, *(please print)* ________________________, consent to the following: In the event of a possible medical emergency, I authorize to be taken to the nearest medical facility for care. I authorize the disclosure of the information on this form to Huliauapaʻa and medical facility personnel. I authorize them to contact my emergency contacts and family physician regarding the information provided on this form and my medical emergency.

Name of participant *(please print)*: __________________________

Signature: ____________________________

Date: ___________________________