# Emergency Plan

| | |
|---|---|
| Name | |
| DOB | |
| Home address | |

## Who to Contact in Order of Preference:

| | |
|---|---|
| Name | |
| Cell phone | |
| Alternate phone | |
| Relationship | |

| | |
|---|---|
| Name | |
| Cell phone | |
| Alternate phone | |
| Relationship | |

| | |
|---|---|
| Name | |
| Cell phone | |
| Alternate phone | |
| Relationship | |

| | |
|---|---|
| Name | |
| Cell phone | |
| Alternate phone | |
| Relationship | |

## Medical Summary:

| | |
|---|---|
| Diagnoses | |
| Medications | |
| Allergies | |
| Doctor | |
| Office | |
| Fax | |
| Specialty | |

Current immunization record & Medical Insurance cards attached

Initial and date