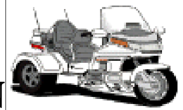
EMERGENCY RIDER/CO-RIDER INFORMATION



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 GWRRA 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 / N0

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
ARTIFICAL 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)

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

SIGNATURE____DATE_____________________