Emergency Contact, Medical Information and Authorization Form

This information will be extremely important in the event of an accident or medical emergency. Please be sure to sign, date and return this form.

Participant(s)

Name: ____
Last First MI

Home Phone: ____________ Cell:____________ Date of Birth: __________
MM/DD/YYYY

Address: ________________ City: __________ State: _____ Zipcode: _____

Primary Emergency Contact

Last Name: ________________ First Name: ________________

Relationship: ________________ Email: ________________

Home Phone: ____________ Cell: ____________ Work Phone: ____________

Secondary Emergency Contact

Last Name: ________________ First Name: ________________

Relationship: ________________ Email: ________________

Home Phone: ____________ Cell: ____________ Work Phone: ____________

Signature: ________________ Date: ____________

Down Syndrome Organization of Southern Nevada
dsosn@dsosn.org | 702.648.1990 | www.dsosn.org
5300 Vegas Drive, Las Vegas, NV 89108