DURHAM ARTS COUNCIL, INC.

VOLUNTEER EMERGENCY INFORMATION

NOTE: This information is strictly confidential and will be used only in the event of an emergency, when you cannot give this information yourself. Giving this information is mandatory although you may choose not to provide all of the information. Please put your name and your guardian/parent's name on the line below, sign on the reverse of this sheet, and give this sheet to the DAC School Manager along with your application materials. In case of an emergency DAC will do whatever possible to meet your requests below however, we are bound by the information you have provided.

Your Name: ________________________________

1. Are you covered by health insurance? ( ) Yes ( ) No

   If yes, what is the name of the insurance carrier?

   _____________________________________Your account #:____________________

2. Name, address and phone numbers of person(s) to be identified in case of an emergency:

Contact #1:

Name: _______________________________ Relationship:_______________

Address: ____

City: ________________________ State:__________ Zip:___________

Day Phone: ________________________ Night Phone:________________

Mobile Phone:__________________________

Contact #2:

Name: _______________________________ Relationship:_______________

Address: ____

City: ________________________ State:__________ Zip:___________

Day Phone: ________________________ Night Phone:________________

Mobile Phone:__________________________

3. Name(s) and phone number(s) of doctors or other health professional(s) who should be notified in case of an emergency:

Name:_______________________________________ Phone:_____________________

Name:_______________________________________ Phone:_____________________

Name:_______________________________________ Phone:_____________________

4. Do you have any chronic or other medical conditions that health care professionals should know about in the event of an emergency? ( ) yes ( ) no

   If yes, please list: ____

   ____

5. Do you regularly take prescription drugs? ( ) yes ( ) no

   If yes, please list: ____

   ____

6. Do you have chronic allergies, including allergies to medicines? ( ) yes ( ) no

   If yes, please list: ____

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7. Do you regularly wear contact lenses: ( ) yes ( ) no

8. Please list your religious affiliation (if any) that you would want a health-care provider to know: ____

9. Other information that a health professional should know in case of an emergency:

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10. Preferred hospital: ____

Print name:____

Signature: ____ Date: __________

Parent/Guardian Name (Print): ___________________________

Parent/Guardian Signature: _____________________________ Date:__________