



**Participant Emergency Contact Form**

Please fill out this form and return to PCRG prior to project participation.

**Mail:** P.O. Box 745309 Arvada, CO 80006 **Email:** [britni.rockwell@paleocultural.org](mailto:britni.rockwell@paleocultural.org)

**Participant Contact Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Medical Information:**

*This information is being collected to ensure your health and safety while participating on this project. All of this information will be kept confidential and will be destroyed at the end of the project. Please fill out this information as completely as possible and with this scenario in mind: if a medical emergency occurs and you are not able to communicate to medical personnel yourself, what information would they need to know to treat you safely and completely? This form will allow us to provide such information on your behalf.*

Date of Birth: \_\_\_\_\_

Are there any physical conditions that limit your activities? Please describe condition(s) and types of activities that should be avoided.

Do you have any allergies to plants, foods, or medicines?

List the medications you take.

Who is your health insurance provider?

Is there any family medical history that you would want a doctor to know about?

**Person to Contact in an Emergency** (Please list contacts that we can reach during work hours):

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Number(s) \_\_\_\_\_

If Emergency Contact is not available, my second choice is:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Number(s) \_\_\_\_\_