

EMERGENCY CONTACT FORM

Oahu Hawaiian Canoe Racing Association

THIS FORM MUST BE TURNED IN WHEN YOU REGISTER

PARTICIPANTS NAME: _____ **DOB:** _____

Street Address: _____ (Apt. #): _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Medical Insurance Coverage: ___ HMSA ___ KAISER ___ HMA OTHER _____

Physician's Name: _____ **Hospital:** _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

1) **Name:** _____ **Relationship:** _____

Street Address: _____ (Apt. #): _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

2) **Name:** _____ **Relationship:** _____

Street Address: _____ (Apt. #): _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____