EMERGENCY CONTACT AND CURRENT MEDICATION INFORMATION

VOLUNTEER INFORMATION			
Name:	**Date of Birth:**		
Home Address: **Mailing Address:**			**Home:** **Cell:**
Physician(s):	**Physician's Phone Number:**	**Pharmacy:**	**Pharmacy's Phone Number:**

EMERGENCY CONTACTS				
NAME	**RELATIONSHIP**	**HOME PHONE**	**MOBILE PHONE**	**WORK PHONE**

MEDICAL CONDITIONS		
1.	**2.**	**3.**
4.	**5.**	**6.**

ALLERGIES TO MEDICATIONS	
MEDICATION	**REACTION**

Do you give Dreams Go On, Inc. permission to seek medical help in the event of an emergency?

__ Yes, I give my consent. **__No, I do not give my consent.**

_____ _____ _____

Print **Signature** **Date**