Pooler Youth Council

Emergency & Medical Information Form

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City of Pooler – Youth Council Program

Participant Information

• Full Name: _____

• Date of Birth: _____ Age: _____

• Address: _____

• Phone Number: _____

• Email: _____

Parent/Guardian Information

• Parent/Guardian Name: _____

• Phone Number(s): _____

• Email: _____

Emergency Contact (if different from above)

• Name: _____

• Relationship: _____

• Phone Number: _____

Medical Information

Please list any medical conditions, allergies, or health concerns we should be aware of (including

asthma, diabetes, food allergies, medications, etc.):

• Does the participant carry medication? (e.g., inhaler, EpiPen)

☐ Yes ☐ No

If yes, please explain: _____

Physician Information (Optional)

• Physician Name: _____

• Phone Number: _____

Medical Treatment Authorization

I authorize the City of Pooler and its representatives to seek emergency medical treatment for my child if I cannot be reached.

Parent/Guardian Signature: _____

Date: _____