

Emergency Contact Information

(This information is kept for emergency purposes only)

Date: _____

Name: _____

Street Address: _____

City, State ZIP _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Allergies: _____

1st Emergency Contact Name: _____

Relationship: _____

Cell Phone: _____

Day Phone: _____

Evening Phone: _____

2nd Emergency Contact Name: _____

Relationship: _____

Cell Phone: _____

Day Phone: _____

Evening Phone: _____

I understand in the event a participant becomes injured while participating in Workforce Development, Inc.'s program, Workforce Development, Inc. staff will transport the participant to the nearest emergency room and/or call 911.

Participant's Signature)

Date

Parent/Guardian Signature (If Applicable)

Date