

**NORTHWATERS TEENS ENCOUNTER CHRIST  
EMERGENCY MEDICAL INFORMATION**

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

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

Parent(s)/Guardian Name: \_\_\_\_\_

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

Spouse/Significant Other Name: \_\_\_\_\_

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

Name of Insurance Company: \_\_\_\_\_

Policy/ID#: \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Physician/Clinic: \_\_\_\_\_

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

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

Special dietary/medical information \_\_\_\_\_

\*In the event of a medical emergency and the above listed physician/clinic is unavailable, I hereby give permission to the TEC leadership to select and secure proper treatment for myself or the person listed above. I certify that I fully understand the above authorization and that I understand that no guarantee or assurance has been made as to the results that may be obtained.

Signature: \_\_\_\_\_  
(Participant)

Signature: \_\_\_\_\_  
(Parent/Guardian – if youth)

Date: \_\_\_\_\_

This information is strictly confidential and will be used only in an emergency.  
**PLEASE BRING THIS FORM WITH YOU TO THE FIRST  
OVERNIGHT TEAM MEETING.**