

**PLEASE DO NOT REMOVE HELMET UNTIL I AM EXAMINED BY A DOCTOR**  
**EMERGENCY INFORMATION FORM**

Effective Dates: From: \_\_\_\_ (dd) \_\_\_\_ (mm) \_\_\_\_ (yyyy) to: \_\_\_\_ (dd) \_\_\_\_ (mm) \_\_\_\_ (yyyy)

\_\_\_\_ I am driving the: \_\_\_\_ (color) \_\_\_\_ (make) \_\_\_\_ (model) \_\_\_\_ (year) motorcycle.

\_\_\_\_ I am the co-rider on the above motorcycle

Relationship to driver: \_\_\_\_ (self) \_\_\_\_ (spouse/significant other) \_\_\_\_ (child) \_\_\_\_ (other: \_\_\_\_)

Photo(s) for identification attached: \_\_\_\_ Yes \_\_\_\_ No

Driver Name: ____ (first) ____ (middle) ____ (last)		
Home Phone: (____) _____		Work Phone: (____) _____
Address: _____		City: _____ State/ZIP: _____
Date of Birth: ____ (dd) ____ (mm) ____ (yyyy)		Sex: ____ Social Security # ____ -- ____ --
Drivers License #: _____ State: _____		
GWRRA Member #: _____		Home Chapter and State: _____
Chapter Contact Name: _____		Chapter Contact Phone #: _____

<b>Emergency Contact Name:</b> ____ (first) ____ (last) Relationship to me: _____	
Phone/home: (____) _____	Phone/work:(____) _____ Phone/cell:(____) _____
<b>Emergency Contact #2:</b> ____ (first) ____ (last) Relationship to me: _____	
Phone/home: (____) _____	Phone/work:(____) _____ Phone/cell:(____) _____

\*Do not leave an emergency message on an answering machine. Contact must be made directly to a person.\*

<b>Health Insurance</b>
Company: _____
City/State: _____
Phone #: _____
Policy/Group#: _____
Other info: _____

<b>Vehicle Insurance</b>
Company: _____
City/State: _____
Phone #: _____
Policy/Group#: _____
Other info: _____

Blood Type: _____
Blood Pressure: _____
Height: _____ Weight: _____

Wear Contact Lenses? ____ Yes ____ No
Wear Dentures? ____ Yes ____ No
Other? (hearing aid, pacemaker, etc.) _____

<b>Allergies to Medications/Allergies to other items:</b>
1. _____
2. _____
3. _____
4. _____
Continued on back side? ____ Yes ____ No

<b>Medications (including supplements, herbs, etc.) Currently Being Used:</b>
1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
Continued on back side? ____ Yes ____ No

<b>Family Doctor:</b> (Attach their business card, if available)
Name: ____ (first) ____ (last)
Address: _____
City: _____ State: _____ ZIP: _____
Phone: (____) _____

<b>Special Notes/Health:</b>
_____
_____
_____

I authorize emergency medical treatment by an EMT, doctor, dentist, and/or hospital when my direct authorization cannot be given: _____ Date: _____
Advanced Directive for Health Care attached? ____ Yes ____ No My doctor listed above has a copy ____ Yes ____ No

Before each trip, it is highly recommended to make an updated copy of this form--as well as a photograph of yourself and your co-rider--if applicable--and place them in a zipper top-type bag in the storage compartment to the left of your motorcycle dashboard for easy access by emergency personnel. It is also recommended if you are riding with other persons that you exchange copies of your emergency information and keep a copy in your respective storage compartments so emergency personnel know who was on each motorcycle.