



# SIGMA ALPHA IOTA MEDICAL EMERGENCY FORM

Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Day- \_\_\_\_\_ Evening- \_\_\_\_\_

Cell- \_\_\_\_\_

IN CASE OF EMERGENCY PLEASE NOTIFY THE FOLLOWING PERSON:

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Day- \_\_\_\_\_ Evening- \_\_\_\_\_

Cell- \_\_\_\_\_

IF FIRST EMERGENCY CONTACT NOT AVAILABLE, ALTERNATE CONTACT:

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Day- \_\_\_\_\_ Evening- \_\_\_\_\_

Cell- \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

List any medical conditions we should be aware of and any medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

List any allergies to food, medications, bees, other:

\_\_\_\_\_  
\_\_\_\_\_

Sign & date below to authorize medical treatment in case of an emergency:

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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**We respect the privacy of our members and will maintain the confidentiality of your health information.**