

HISTORIC ST. MARY'S CITY

A MUSEUM OF HISTORY & ARCHAEOLOGY AT
MARYLAND'S FIRST CAPITAL

EMERGENCY INFORMATION

The following information will be kept in the department office and used only in the event of an emergency.

Participant's Name: _____ D.O.B.: _____

Home Address: _____

Home Phone: _____

First Person to Notify in Case of Emergency

Name: _____ Relationship: _____

Daytime phone: _____ Evening phone: _____

Second Person to Notify in case above cannot be reached

Name: _____ Relationship: _____

Daytime phone: _____ Evening Phone: _____

Medical Information

In the space below please provide any medical information, allergies, medications, doctor's names, or any information that medical personnel should be aware of in case you are not able to provide it yourself.

Date Completed: _____

Participant's Initials: _____