Emergency Contact and Medical Form

Event: Kappa Phi Gamma Sorority, Inc. and Delta Epsilon Psi Fraternity, Inc. National Convention 2025
Date(s): June 12-15 2025
Location: Nashville, Tennessee

Participant Information
Full Name: _____
Date of Birth: _____
Address: _____
City, State, ZIP: _____
Email: _____
Phone Number: _____

Emergency Contact Information
In case of emergency, please contact the person(s) listed below:

1. **Primary Emergency Contact**
   Name: _____
   Relationship to Participant: _____
   Phone Number: _____
   Alternate Phone Number: _____
2. **Secondary Emergency Contact**
   Name: _____
   Relationship to Participant: _____
   Phone Number: _____
   Alternate Phone Number: _____

Medical Information

- **Primary Care Physician's Name:** _____
- **Physician's Phone Number:** _____
- **Allergies (if any):** _____
- **Medications (if any):** _____
- **Chronic Conditions (if any):** _____
- **Special Medical Needs or Considerations:** _____

Consent for Medical Treatment
In the event of an emergency where I am unable to give consent, I authorize the conference organizers or their representatives to seek medical treatment for me. I understand that I am responsible for any costs associated with such medical treatment.
Signature
Participant's Signature: _____
Date: _____

Parent/Guardian Consent (if participant is under 18)
As the parent or legal guardian of the minor participant, I consent to the minor's participation in the Kappa Phi Gamma Sorority, Inc. and Delta Epsilon Psi Fraternity, Inc. National Convention 2025 and authorize the conference organizers to seek emergency medical treatment on their behalf if necessary.
Parent/Guardian's Name: _____
Parent/Guardian's Signature: _____
Date: _____