



EMERGENCY CONTACT FORM
Hawaiian Canoe Racing Association

THIS FORM MUST BE TURNED IN WHEN YOU REGISTER

PARTICIPANTS NAME: _____ DOB: _____

Street Address: _____ (Unit): _____

City: _____ State: _____ Zip Code: _____

Home Phone : _____ Work : _____ Cell : _____

Medical Insurance Coverage: HMSA _____ KAISER _____ HMA _____

OTHER _____ Physician's Name: _____

Hospital: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

1) Name: _____ Relationship: _____

Street Address: _____ (Unit): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work : _____ Cell : _____

2) Name: _____ Relationship: _____

Street Address: _____ (Unit): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work : _____ Cell : _____

Turn in at registration.