

EMERGENCY CONTACT FORM
Oahu Hawaiian Canoe Racing Association

THIS FORM MUST BE TURNED IN WITH THE HCRA INSURANCE WAIVER

Participant's Name _____ DOB _____

Street Address _____

Home Ph. _____ Work# _____ Cell _____

Medical Insurance Coverage ___ HMSA ___ Kaiser ___ HMA ___ Other

Physician's Name _____ Hospital _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

1) Name _____ Relationship _____

Address _____

Home # _____ Work # _____ Cell # _____

2) Name _____ Relationship _____

Address _____

Home # _____ Work # _____ Cell # _____