

University of Idaho Extension
Idaho Master Gardener™ Program

EMERGENCY CONTACT FORM

College/Department

Activity Name

Date

Location

Name (First)

(Last)

Address

City

State

Zip

Phone (Cell)

(Home)

Primary Emergency Contact Name

Relationship

Phone (Cell)

(Home)

(Work)

Secondary Emergency Contact Name

Relationship

Phone (Cell)

(Home)

(Work)

PLEASE NOTE: Hospitals and clinics require Social Security numbers before providing treatment and suggest that participants bring a copy of their insurance card. **The participant is responsible for all medical expenses.**

The contact information provided will be shared only in the case of an emergency.