Name: _____

In case of Emergency, contact: _____

Phone: _____

Chronic Medical Conditions:

Medications:

Allergies:

Primary Care Physician: _____

Preferred Hospital: _____

By signing, I authorize the above information on this form to be released and disclosed to Alien Graphics for printing Ship Membership ID Cards. I understand that I am not required to disclose any information and that this information is only for the convenience of emergency medical personnel.

Signed by: _____ _____

Signature of Ship Member or Legal Guardian | Relationship to Ship Member

_____ _____

Print Name of Ship Member | Date

_____

Print name of Legal Guardian, if applicable