

# TOWN OF UPTON, MASSACHUSETTS

## Emergency Contact Information Form

**This information will be extremely important in the event of an accident or medical emergency.**

**Please be sure to sign and date this form**

**Name:** \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

**Phone:** \_\_\_\_\_  
**Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Home Email Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Primary Emergency Contact Name:** \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Secondary Emergency Contact Name:** \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Preferred Local Hospital:** \_\_\_\_\_

**Insurance Information:**

**Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Comments** (include any special medical or personal information you would want an emergency care provider to know – or special contact information):

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_