RCT ALPINE STAGES CYCLING TRIP
EMERGENCY CONTACT INFORMATION

CYCLIST (PARTICIPANT'S) INFORMATION

NAME: _____ **MALE** ___ **FEMALE** ___

STREET ADDRESS: _____ **CITY:** _____

STATE/PROVINCE: _____ **ZIP/POSTAL CODE:** _____ **COUNTRY:** _____

HOME PHONE: _____ **CELL:** _____

E-MAIL: _____

EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT (family member, etc. who will NOT be traveling with you): _____

HOME PHONE # OF EMERGENCY CONTACT: _____

CELL # OF EMERGENCY CONTACT: _____

CONSENT TO EMERGENCY MEDICAL TREATMENT

I, _____ CONSENT TO MEDICAL TREATMENT IN THE CASE OF A MEDICAL EMERGENCY THAT RENDERS ME UNABLE TO COMMUNICATE HEALTHCARE DECISIONS FOR MYSELF, DURING THE PERIOD THAT I WILL BE PARTICIPATING IN THE REILLY CYCLING TOURS TRIP.

_____ _____
(participant's signature required) **(date)**

_____ _____
(signature of witness) **(date)**

_____ _____
(signature of witness) **(date)**

PLEASE NOTE!

- **THIS FORM MUST BE RECEIVED PRIOR TO THE START OF YOUR REILLY CYCLING TOURS TRIP**

If you have any questions, please contact us at (631) 484-6545