

**ACADEMIC OFF-CAMPUS EVENT EMERGENCY INFORMATION FORM**

Participant's Name \_\_\_\_\_ SS# \_\_\_\_\_

*Last First MI*

Home Address \_\_\_\_\_

Telephone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

**EMERGENCY CONTACT(S) (Names and Phone Numbers)**

Name \_\_\_\_\_ Address \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Personal Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

I am presently under the following medication \_\_\_\_\_

I am presently allergic to the following medication \_\_\_\_\_

Presently wear contact lenses? \_\_\_\_\_ Presently wear glasses? \_\_\_\_\_

Please state any medical conditions that emergency care providers need to be aware of

\_\_\_\_\_  
\_\_\_\_\_

Do you have health insurance? \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Insured (if different from self) \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Company \_\_\_\_\_ Telephone # \_\_\_\_\_

Address of Company \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Participant

Copy distribution: Event Leader  
Appropriate College/School, Department or Program  
University Police