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 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 _____

If I need medical treatment arising out of my participation in this activity, I give my consent for the university to release the information on this form to any medical professional.

Signed _____ Date _____
Signature of participant, or parent or legal guardian, if participant is a minor.