STUDENT EMERGENCY INFORMATION FORM

Participant's Name _____ Date of Birth _____
Last *First* *MI*

Emergency Contact Information (required)
Emergency Contact #1 must be able to make legal decisions for you in a worst-case scenario.

	Emergency Contact 1	Emergency Contact 2
Last, First Name		
Relationship		
Street Address		
City, State, Zip, Country		
Phone: Home		
Phone: Work		
Phone: Cell		

Medical Information (optional)

Hospital/Clinic Preference _____

Medical Insurance Company _____

Policy/Group Number _____

Phone Number_____

Do you have any allergic reactions to bee/insect stings, medications, food/drink, etc.?
If yes, please explain and note associated reaction(s) below:
_____
_____

Do you have any medical information that may be pertinent to your emergency care (such as: pre-existing conditions or essential medications)? *If yes, please explain below:*
_____
_____

PLEASE NOTE
Completing the medical information section of this form is voluntary. It will be referred to ONLY in case of a critical injury or emergency situation. In the instance that you are unable to provide medical information to an attending physician or hospital, we would be able to provide it for you with your consent by signing below.

_____ _____
Signature Date