

## EMERGENCY CONTACT & MEDICAL INFORMATION

Student Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Study Abroad Destination:

Host University/City: \_\_\_\_\_ Country: \_\_\_\_\_

Host University Advisor/Instructor \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number Abroad: \_\_\_\_\_

### In case of accident or illness contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ **Email (Required\*):** \_\_\_\_\_

**\*Emergency contact must have an email address. If they do not, please change contact information to someone who has an email address.**

### Medical Information (optional):

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

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

**PLEASE NOTE:** Completing the medication 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.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

### Return this form to:

Study Abroad & International Exchanges  
Family and Food Science, Room 119  
California State University, Fresno  
5300 N. Campus Drive M/S FF83  
Fresno, CA 93740-8019