EXAMPLE—Emergency Contact Information Form—EXAMPLE

PLEASE PRINT LEGIBLY

** This form is provided as an example for student organizations to use when conducting activities that may or may not incur risk. It is the responsibility of each organization to assess risk and determine when and how participant information is collected or retained.

Participant's First Name:______________________________________

Participant's Last Name:______________________________________

Student ID#:______________________________________

Organization:______________________________________

Goldmail:______________________________________

Do you have health insurance: Yes No

Cell Phone: ______________________________________

Gender: M F DOB: ______________________________

Local Address:______________________________________

____

City/State:______________________________________

Zip:________________________

Permanent Address:__________________________________

____

City/State:______________________________________

Zip: ___________________

Home Phone: ______________________________________

<u>Who to Notify in Case of Emergency</u>

Name____ Relationship ______________________________________

Address____ State__________ Zip____________________

Cell Phone (________)_____________________ Work Phone (____)_____________________Home Phone (____)______________________

<u>Insurance & Health Information:</u>

Company_______________________________________ Policy #_________________________Exp. Date________

Do you wear contact lenses? YES NO If yes, do you wear them during physical or athletic activity? YES NO

Do you have any allergies, seasonal or otherwise? YES NO

If yes, please list: ____

Are you currently taking any prescription or non-prescription medication? YES NO

If yes, please list: ____

Are you taking any medications regularly? YES NO

If yes, please list: ____

6. Do you have any respiratory problems? YES NO Do you have asthma? YES NO

If yes, please list: ___________________________________ Do you use an inhaler? YES NO

7. Have you ever suffered a head injury? YES NO Have ever had a concussion? YES NO

If yes, when and was it severe enough to see a doctor? ____

8. Do you have any medical conditions, past surgeries, hospitalizations or history of injury that would be important in the event of an emergency or that may restrict your participation in physically demanding or athletic activity? (Diabetes, high blood pressure, epilepsy, dislocated shoulder, knee, etc.) YES NO

If yes, please list: ____

Give approximate date of your last Tetanus shot: _________________

*****If any of this information changes, please update with the organization's coordinator immediately*****