Office of Risk Management

Emergency Contact Information

Last Name ________________________________ **First Name** ____________________________

Are you 18 or over? Yes No **Birth Month and Day ONLY**____________________

Student ID ______________ **Cell** ________________ **E-Mail Address** ____________________

Faculty/Coordinator__________________________ **Date of Event**__________________________

Course # (if applicable) _________________________

Emergency Contact Information (print clearly)

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

Other Information

Do you have any allergic reactions to:

Bee/Insect Stings Yes No **Medications** Yes No **Food/Drink** Yes No **Other** Yes No

If you answered yes to any of the above, please explain and note reaction:

Do you have any dietary restrictions (vegetarian, etc.)? If yes, please explain:

PLEASE NOTE

Information on this form 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