**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: _______________________________________

Who to Notify in Case of Emergency

Name ____________________________ Relationship ___________
Address ____________________________________________ State ______ Zip __________
Cell Phone (_____) Work Phone (_____) Home Phone (____)

Insurance & Health Information:

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***