

# Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Please be sure to sign and date this form

Student's Name: \_\_\_\_\_  
Last First MI

Phone:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Home Address: \_\_\_\_\_  
Street State Zip Code

Primary Emergency Contact Name: \_\_\_\_\_  
Last First

Relationship: \_\_\_\_\_ Phone:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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

Secondary Emergency Contact Name: \_\_\_\_\_  
Last First

Relationship: \_\_\_\_\_ Phone:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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

Preferred Local Hospital: \_\_\_\_\_

**Insurance Information:**

**Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Comments** *(include any special medical or personal information you would want an emergency care provider to know – or special contact information):*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_