ISU EMERGENCY CONTACT AND MEDICAL INFORMATION FORM

PARTICIPANT INFORMATION

Participant's Name _____ University ID # _____

Permanent Address _____ Date of Birth _____

City, State, Zip _____ Home Phone ( ) _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First:

Name _____

Relation to Participant _____

Daytime Phone ( ) _____

Evening Phone ( ) _____

Backup Contact (Relative or Friend):

Name _____

Relation to Participant _____

Daytime Phone ( ) _____

Evening Phone ( ) _____

Are you allergic to any medications? _____

INSURANCE POLICY INFORMATION

❒ Yes The above-named participant is covered by health insurance. If yes, provide the following information

❒ No **If no**, initial this line stating that you do not have health insurance and are aware that Iowa State University does not carry any health insurance for you. _____

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____

Address _____ Relation to Participant _____

City, State, Zip _____ Occupation _____

P.H.'s Employer's Name _____

Employer Address _____

Insurance Company Name _____

Insurance Company Address _____

Policy # _____ Plan # _____

MEDICAL EMERGENCY PERMISSION

If an accident, injury or other medical condition occurs or arises, I hereby give permission to an ISU representative to contact the individual(s) that I have listed under Medical Emergency Contact information.

_____ _____

Date Name (please print)

_____

Signature

_____

Signature of Parent or Guardian (if under 18)