University of California, Santa Barbara

Emergency Information & Contacts

DEPARTMENT & ACTIVITY

Department ______________________ Class/Activity ______________________

NAME OF PARTICIPANT

Name: ______________________ Birthdate: ____________

Address: ______________________

Work Ph: ____________ Home Ph: ____________ Email: ______________________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________________

Address: ______________________

City: ______________________ State, Zip Code: ______________________

Work Ph: ____________ Home Ph: ____________ Email: ______________________

Name: ______________________ Relationship: ______________________

Address: ______________________

City: ______________________ State, Zip Code: ______________________

Work Ph: ____________ Home Ph: ____________ Email: ______________________

NAME OF PHYSICIAN

Physician's Name: ______________________ Phone: ____________

Address: ______________________

City: ______________________ State, Zip Code: ______________________

NAME OF INSURANCE COMPANY

Name of Medical Insurance Provider : ______________________

Address: ______________________

City: ______________________ State, Zip Code: ______________________

Policy No: ______________________ Expiration Date: ______________________

IMPORTANT: ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD

SPECIAL CONDITIONS

If you have a medical problem or are taking medication that would be important for us to be aware of, please indicate here

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SIGNATURE

Signature: ______________________ Date: ____________