Emergency Contact and Medical Information Form

The information on this form will be kept in the possession of The Johns Hopkins University, Center for Social Concern. A copy will also be distributed to the person in charge of each trip or activity in which the student participates.

Date: _____

Name: _____ Email address:_____

JHED ID:_____ Date of birth:_____

Home address: _____

(Street) (City) (State) (Zip)

Primary phone: _____ Alternate phone: _____

PRIMARY EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Home address: _____

(Street) (City) (State) (Zip)

Primary phone: _____ Alternate phone: _____

ALTERNATE EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Home address: _____

(Street) (City) (State) (Zip)

Primary phone: _____ Alternate phone: _____

INSURANCE

Company: _____ Policy number: _____

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MEDICAL HISTORY

Medications you are taking: _____

Known allergies: _____

Previous injuries, major illnesses, and surgeries: _____

_____

Other information for an emergency responder: _____

CONSENT AND AUTHORIZATION:

I certify that I am 18 years of age or older and that the information on this form is accurate and complete. Should the need arise, I authorize that the information on this form can be released to the proper medical authorities so medical treatment can be administered.

SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____
(if under 18 years of age)