



Emergency Contact/Medical Consent Form

Organization _____
 Date(s) of Activity _____ Location of Activity _____

Student Information

Name (Last, First, MI) _____ Date of Birth _____
 Address _____ Telephone (home) _____
 City _____ Telephone (work/other) _____
 State/Zip _____ Telephone (mobile) _____

Emergency Contact (list at least one)

		Contact #1	Contact #2
Name		_____	_____
Telephone	Home	_____	_____
	Work	_____	_____
	Mobile	_____	_____
Address		_____	_____
City/State/Zip		_____	_____
Relationship to Student (circle one)	Spouse Relative	Parent/Guardian Friend	Spouse Relative Parent/Guardian Friend

Medical Information (attach extra pages if necessary)

1. Describe all prescription medications or special medical care you require. If none, write NONE.

2. Describe all medications to which you are allergic. If none, write NONE.

3. Describe all other allergies (including food) or special medical conditions. If none, write NONE.

4. Provide Name, City and Telephone number to your physician.

5. Are you covered under a medical/hospitalization insurance plan? If no, write NONE. If yes, provide the following information: _____

Insurance Company _____ Policy Number _____
 Name of Insured _____
 Employer/Group Name _____

In the event of a serious medical emergency, I authorize San Jacinto College, its employees, and/or other agents (collectively the College) to secure medical transportation or treatment on my behalf. I understand that the College is not required to obtain medical transportation or care for me. I understand that the College will attempt to contact one of the individuals I have designated as an emergency contact. I authorize the College to release the information on this form to health care providers for the purpose of securing health care services for me. I understand and agree that I am responsible for all expenses, fees, or costs incurred as a result of the medical transportation or care secured for me by the College. I understand and agree that the College is not liable for any injury or damages that may occur as a result of medical treatment that I may receive.

Student Signature

Date