Office of International Activities

UNC SCHOOL OF MEDICINE

Emergency Contact Form

Last Name	**First Name**	**Date of Birth:** ___/___/___ Month Day Year	
E-mail	**Student Cell Phone**	**Gender:**	☐ Male ☐ Female ☐ Transgender
Home Address (include city and state)	**Parent/Guardian Home Phone**	**Parent/Guardian Work Phone**	
Emergency Contact Name 1	**Relationship**	**Primary Contact Phone:** **Alternate Contact Phone/email:**	
Emergency Contact Name 2	**Relationship**	**Primary Contact Phone:** **Alternate Contact Phone/email:**	
Local Emergency Contact Name (family, landlord)	**Relationship**	**Primary Contact Phone:** **Alternate Contact Phone/email:**	
Home Medical School Contact Name	**Position Title**	**Primary Contact Phone/email:** **Alternate Contact Phone/email:**	

Allergies to medications? Yes No *(If yes, please list)*

Severe food allergy? Yes No *(If yes, please list)*

Is an EpiPen® prescribed? Yes No **Insect allergy? Yes No** **Environmental allergy? Yes No**

Current or past medical, surgical, or psychiatric condition(s). *Please list and include relevant medical information:*

Prescription medication(s) *Please list and include dosage:*

Vitamins, supplements and over-the-counter medications taken regularly *Please list:*

Questions? E-mail us **international@med.unc.edu**