

EMERGENCY CONTACT FORM

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell. # \_\_\_\_\_

**Emergency Contact Information**

Primary Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Physical Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Alternate telephone # \_\_\_\_\_

Secondary Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Telephone # \_\_\_\_\_

Alternate telephone # \_\_\_\_\_

**Allergies** (please list all): \_\_\_\_\_

\_\_\_\_\_

**Medical Conditions/Illnesses/Medications** (please list all): \_\_\_\_\_

\_\_\_\_\_

I give permission to The University of Kansas Medical Center – International Programs – to contact my emergency contacts in case of an emergency

Signature \_\_\_\_\_