

FORM 1



REQUIRED EMERGENCY MEDICAL INFORMATION
School of Equine Studies

Student Name _____ DATE _____

Student signature _____

Date of Birth _____

Campus Address _____

Email: _____

Campus Phone _____

Cell Phone _____

Home Address _____

Parent/Guardian Name(s): _____

Home Phone _____

Alt. Phone _____

In Case of an emergency, contact:

His/Her Relationship to you:

Emergency contact person's home phone _____

Emergency contact person's cell phone _____

Your known health problems:

Your known allergies:

Current medications:

Medical Health Insurance Company: _____

Policy # _____ Group # _____ Plan # _____

Space for copy of FRONT and BACK of current medical insurance card: