



## Emergency Medical Information Form

**PURPOSE:** This forms sole purpose is to alert the instructor of this course and any medical providers of conditions that might affect your care in case of emergency. This form is confidential and will be destroyed at the conclusion of the course.

You are REQUIRED to carry your BC Health, or other provincial health, card with you at all times.

### PLEASE PRINT CLEARLY

#### Personal Information

Name: \_\_\_\_\_ UBC Student #: \_\_\_\_\_

Health Care Number: \_\_\_\_\_ Province of Health Care: \_\_\_\_\_

Current Home Address: \_\_\_\_\_

Current Phone #: \_\_\_\_\_

Permanent Home Address: \_\_\_\_\_

Permanent Phone #: \_\_\_\_\_

#### Emergency Contacts

**PRIMARY** Contact Name: \_\_\_\_\_ Relationship (eg Spouse): \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

**SECONDARY** Contact Name: \_\_\_\_\_ Relationship (eg Spouse): \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

#### Medical Information

Family Doctor's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Clinic/Doctor's Office Address: \_\_\_\_\_

Do you have any physical or mental conditions that could be a health/safety factor at any time during this trip?

Yes                      No                      If yes, please describe:

Are you taking any prescription or over-the-counter medication for any condition described above?

Yes                      No                      If yes, please list:

Do you have any allergies?

Yes                      No                      If yes, please describe:

Do you carry any medications (e.g. epi-pen) for emergency situations?

Yes                      No                      If yes, please describe:

Do you have any first aid training?

Yes                      No                      If yes, please describe:

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I, \_\_\_\_\_, submit this form and attest that the information is true and correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_