JOHNS HOPKINS UNIVERSITY | Homewood Student Affairs
Center for Social Concern

# Emergency Contact and Medical Information Form

The information on this form will be kept in the possession of The Johns Hopkins University, Center for Social Concern. A copy will also be distributed to the person in charge of each trip or activity in which the student participates.

| | |
|---|---|
| **Program /Field Trip Name:** | |
| **Date Completed:** | |

| PARTICIPANT INFORMATION | | | |
|---|---|---|---|
| First & Last Name | | JHED ID | |
| Email Address: | | | |
| Primary Phone: | | Alternate Phone: | |
| Gender: | | Date of Birth: | |
| Address: | | City, State Zip: | |
| List any medications being taken: | | | |
| Allergies (medicine, food, etc.): | | | |
| Any special dietary needs: | | | |
| Previous injuries, major illnesses, and surgeries: | | | |
| Other information for an emergency responder: | | | |

IN CASE OF EMERGENCY, CONTACT

**Primary Contact**

| | | | |
|---|---|---|---|
| First & Last Name: | | Relationship | |
| Primary Phone: | | Alternate Phone: | |
| Address: | | City, State Zip | |

**Alternative Contact**

| | | | |
|---|---|---|---|
| First & Last Name: | | Relationship | |
| Primary Phone: | | Alternate Phone: | |
| Address: | | City, State Zip | |

| |
|---|
| Do you require any dietary, religious, mobility, hearing, vision, or other accommodations in order to participate fully in the program? If yes, please describe: |
| I certify that I am 18 years of age or older and that the information on this form is accurate and complete. Should the need arise, I authorize that the information on this form can be released to the proper medical authorities so medical treatment can be administered. |

| | | | |
|---|---|---|---|
| SIGNATURE: | | DATE | |
| PARENT/GUARDIAN SIGNATURE: | | DATE | |