



University of California, Santa Barbara Emergency Information & Contacts

DEPARTMENT & ACTIVITY

Department _____

Class/Activity _____

NAME OF PARTICIPANT

Name: _____ Birthdate: _____

Address: _____

Work Ph: _____ Home Ph: _____ Email: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

City: _____ State, Zip Code: _____

Work Ph: _____ Home Ph: _____ Email: _____

Name: _____ Relationship: _____

Address: _____

City: _____ State, Zip Code: _____

Work Ph: _____ Home Ph: _____ Email: _____

NAME OF PHYSICIAN

Physician's Name: _____ Phone: _____

Address: _____

City: _____ State, Zip Code: _____

NAME OF INSURANCE COMPANY

Name of Medical Insurance Provider : _____

Address: _____

City: _____ State, Zip Code: _____

Policy No: _____ Expiration Date: _____

IMPORTANT: ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD**SPECIAL CONDITIONS**

If you have a medical problem or are taking medication that would be important for us to be aware of, please indicate here

SIGNATURE

Signature: _____ Date: _____