



## Early College Degree Program

### Emergency Contact & Medical Information Form

Participant's Full Name: \_\_\_\_\_  
(First) (Middle) (Last)

Street Address: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Student's Email Address: \_\_\_\_\_ Student's Cell Phone: (\_\_\_\_) \_\_\_\_\_

**Parent/Guardian 1 Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone Number: (\_\_\_\_) \_\_\_\_\_ Mobile Phone Number: (\_\_\_\_) \_\_\_\_\_

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

**Parent/Guardian 2 Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone Number: (\_\_\_\_) \_\_\_\_\_ Mobile Phone Number: (\_\_\_\_) \_\_\_\_\_

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

In case of an emergency and parents/guardians cannot be reached, who may we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

#### Medical Information

Medical Insurance Company: \_\_\_\_\_ Policy No. \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Allergies: (food, environmental, or insect)

Medications: (name, dosage, route, & interval)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Note: HCC staff are not authorized to administer any medication (prescription, non-prescription, or over the counter) to students.

*My child has my permission to participate in Early College Degree Program activities. Should my child or my legal dependent become injured during this activity, my permission is given to provide or obtain necessary medical attention.*

\_\_\_\_\_

\_\_\_\_\_

Parent Signature

Date