

Study Abroad Participant Emergency Information Form

Valdosta State University

Center for International Programs

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The information requested below will be used only in case of emergency. The medical information will be kept confidential and will be destroyed upon completion of your program.

Name _____
Last First Middle

University _____

Program Name or Destination _____

Date of Birth _____ Male Female

PRIMARY EMERGENCY CONTACT

Name _____ Relationship _____

Address _____

Primary Phone # _____ Alternative Phone # _____
area code + phone number area code + phone number

E-mail Address _____

SECONDARY EMERGENCY CONTACT

Name _____ Relationship _____

Address _____

Primary Phone # _____ Alternative Phone # _____
area code + phone number area code + phone number

E-mail Address _____

MEDICAL INFORMATION

Primary Care Physician's Name _____

Business Phone # _____

Medical Conditions, previous medical procedures, and/or medications that you take on a regular basis. (This information will remain confidential, but is essential in case of emergency.) Use the back of this page if needed.

I authorize the program director, site director, or the EC office to contact the person(s) listed above in the event of an emergency.

Participant's Signature _____

Date _____