



Nursing Department Emergency Information Form

Name of Student _____ ID# _____

1. In the event of an emergency, contact:

A. _____
Name Relationship

Address Home Phone

City State Zip Code Business Phone

B. _____
Name Relationship

Address Home Phone

City State Zip Code Business Phone

2. Name of doctor to be contacted:

Name Phone

3. In the case of sudden illness or accident, will you agree, if necessary, to be transferred to the nearest hospital? _____ Yes _____ No

If no, please specify to which hospital you want to be transferred:

Name of Hospital

Signature _____ Date _____