

**EMERGENCY CONTACT INFORMATION**

In the event of a life threatening or other medical emergency during your enrollment at PrattMWP it is of the utmost importance that we have the most up to date information readily available to our Residential Life and Security staff so that we can provide the best care and help us contact your family at home. This information is kept **STRICTLY CONFIDENTIAL** and is only used in the event of a medical emergency to aide in your care. **Return to the attention of the Residential Life Coordinator.**

**I. Student Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Pratt Student ID#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: ( ) - Student Cell/Alternate: ( ) -

**II. Parent/ Guardian Information**

In the event of a medical emergency I give PrattMWP/ Medical Personnel the authority to contact my parents/ legal guardians to advise of medical status/ condition.

Yes, full authorization granted to advise parents of medical status/ condition.

Yes, but with the restriction(s) of: \_\_\_\_\_

No, I do not authorize permission for medical personnel or PrattMWP staff to speak with anyone about my medical condition.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mother/ Guardian**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Other Contact Information: \_\_\_\_\_

**Father/ Guardian**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Other Contact Information: \_\_\_\_\_

**III. Emergency Medical Information**

*This information may be used when there is a medical emergency to aide EMT's and/or Hospital Emergency Medical personnel.*

1. What is your blood type?  
 Do you carry a blood type card?  YES  NO
2. Do you have any allergies?  YES  NO If Yes, please describe:
3. Do you have any specific medication allergies?  YES  NO If Yes, please describe:
4. Do you have a chronic medical condition?  YES  NO If Yes, please describe:
5. Do you take medication(s) regularly?  YES  NO If Yes, please list:
6. Do you wear a MEDIC ALERT bracelet?  YES  NO
7. Do you carry an "Organ Donor" card?  YES  NO
8. Do you have a Health Proxy Form?  YES  NO (Please attach a copy to this form)
9. Do you have religious practices against certain forms of medical treatment?  YES  NO

Please provide any additional information that you consider important on the reverse side of this form.