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|--|---|---|---|
| <input type="checkbox"/> North Campus          | <input type="checkbox"/> Kendall Campus   | <input type="checkbox"/> Wolfson Campus       | <input type="checkbox"/> West Campus    |
| <input type="checkbox"/> Medical Center Campus | <input type="checkbox"/> Homestead Campus | <input type="checkbox"/> InterAmerican Campus | <input type="checkbox"/> Hialeah Campus |

## Emergency Contact Information

**This document and its contents constitute a student record and are exempt from public records under §1002.22 and §1006.52, Florida Statutes. The contents of this document can only be disclosed in accordance with the Student's and/or Parent(s)/Guardians consent.**

STUDENT NAME

STUDENT NUMBER

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

E-Mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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

\_\_\_\_\_

E-Mail: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

\*Health Insurance Provider: \_\_\_\_\_

Policy No. \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby certify that all of the above information given is true and accurate. I hereby consent to the College disclosing this information for the sole purpose of assessing my/student's medical needs or obtaining medical services on my/student's behalf.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s)/Guardian's Signature

Required for students under 18 years of age

\_\_\_\_\_  
Date

\*This information shall be only disclosed to a healthcare facility should student require medical services and is unable to personally convey this information to the medical service provider.