



**EMERGENCY CONTACT/MEDICAL INFORMATION**

**NAME OF PROJECT:** \_\_\_\_\_

**NAME (As it appears on your passport):** \_\_\_\_\_

**Passport Number:** \_\_\_\_\_ **Expiration date:** \_\_\_\_\_

**EMERGENCY CONTACT PERSON**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone: Day** \_\_\_\_\_ **Evening** \_\_\_\_\_

**ALTERNATE CONTACT (will be used if unable to contact the person listed above)**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone: Day** \_\_\_\_\_ **Evening** \_\_\_\_\_

**PERSONAL PHYSICIAN (optional):** \_\_\_\_\_

**Office Phone Number:** \_\_\_\_\_

**MEDICAL INSURANCE COMPANY:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Brief Medical History (surgeries, conditions):**

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**Medications Currently Taking (include dosage/frequency):**

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**Allergies:**

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**Other pertinent information:**

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PLEASE ATTACH A COPY OF PICTURE/INFORMATIONAL PAGE OF YOUR PASSPORT TO THIS FORM

**DISCLAIMER: Marquette University is not responsible for monitoring medications, medical conditions, diets, food allergies or medication allergies and will only use this information provided in an emergency.**