Social Work Abroad Program
109 E Santa Clara St #150
San Jose, CA 95113

EMERGENCY CONTACT AND MEDICAL INFORMATION

Participant's Name ____________________ Age ____________________

(   ) ____________ Home Phone
(   ) ____________ Cell Phone Abroad
Email Address ____________________

Address ____________________ City, State, Zip Code ____________________

Emergency Contacts

Primary Emergency Contact ____________________ Secondary Emergency Contact ____________________

(   ) ________ Day Phone
(   ) ________ Evening Phone
(   ) ________ Day Phone
(   ) ________ Evening Phone

Email Address ____________________ Email Address ____________________

Relationship ____________________ Relationship ____________________

Medical Insurance Information

Physician's Name ____________________ Phone Number ____________________

Domestic Insurance Provider ____________________ Policy Number ____________________

Traveler Insurance Provider ____________________ Traveler Insurance Policy Number ____________________

Travelers Insurance Provider Phone Number ____________________

Medical History and Information

1. Do you have any medical needs or health conditions that we should be aware of?
   ____
2. Do you have any allergies (medicine, food, animals, plants, mold, etc)?
   ____
3. Are you currently taking any medications? Name and dosage (if possible bring entire prescription bottle with you).
   ____
4. Do you have any dietary needs? Are you a vegan/vegetarian?
   ____
5. Do you have any aversion to animals? If so, which ones?
   ____