

CENTER FOR COMMUNITY SERVICE AND JUSTICE
HEALTH AND EMERGENCY INFORMATION FORM

The following information is required for all participants.
Please complete every space below and make sure that all responses are legible.
If you are currently taking any medications, remember to bring an adequate supply with you on the immersion experience.

Personal Information

Name: _____ Date of Birth: ____ / ____ / ____

Immersion Program: _____ Semester/Year: _____

Home address: _____

Home phone: _____ ID#: _____

E-mail address: _____

Emergency Contacts

Name: _____ Relationship to Participant: _____

Address: _____

Phone (day): _____ Phone (eve/weekend): _____

Phone (cell): _____

E-mail address: _____

Name: _____ Relationship to Participant: _____

Address: _____

Phone (day): _____ Phone (eve/weekend): _____

Phone (cell): _____

E-mail address: _____

Health Insurance Information

Insurance Company Name: _____

Name of Policy Holder: _____ Policy Number: _____

Name of Employer (company/organization): _____

Employer's address: _____

(please continue to page 2)

OPTIONAL: Special Needs

We are concerned about your health and well-being during the program and want you to have a successful experience. If you choose to reveal any information below, it will not affect your status in the program, nor will it be revealed to anyone outside of the CCSJ staff or trip leaders without your written permission. The sharing of this information is strictly voluntary.

Do you have any special needs (such as allergies, dietary needs, etc.) that you would like to identify to assist us in preparing for your participation?

Are there any special accommodations that you would like to request? Please note that we may not be able to provide all accommodations specified.

Emergency Medical Treatment Authorization

I agree to permit Loyola University and its agents and employees to seek emergency medical treatment for me in the event of an injury or illness occurring during this immersion experience. I understand that any costs associated with such treatment are my responsibility.

Signature: _____ Date: _____