

CALIFORNIA STATE UNIVERSITY FULLERTON
College of Humanities & Social Sciences

STUDY ABROAD PROGRAM
EMERGENCY CONTACT AND MEDICAL RELEASE FORM

Student

Name: _____ Program/Year: _____

Primary Contact:

Secondary Contact:

Name: _____ Name: _____

Relation: _____ Relation: _____

Daytime Phone: () _____ Daytime Phone: () _____

Evening Phone: () _____ Evening Phone: () _____

Please list all:

Allergies: _____

Current Medications: _____

Medical Conditions (special diets, treatments, etc.) _____

Do you have health insurance? Yes No

Name of Health Care Provider: _____

I hereby grant the University permission to contact the above named individuals whenever the University, at its sole discretion, determines it is necessary to do so.

Student signature _____ ***Date:*** _____