



Emergency Contact Information

Because of the Health Insurance Portability and Accountability Act (HIPAA), which protects health patient privacy, emergency contact information and permission to release information is required from you, the student. This information will only be used in the event of serious injury or death. Please provide a contact person who can make important medical decisions for you, if you are unable to do so for yourself.

Student Information

Family Name (Surname): _____ First Name: _____

Middle Name: _____ Date of Birth: _____
(MM/DD/YYYY)

Health Insurance Provider: _____

Health Insurance ID Number: _____

Health Insurance Street Address: _____

City: _____ State: _____ Postal Code: _____

Country: _____ Phone Number: _____

****If you are currently covered by health insurance in your home country, please ensure this coverage is valid in the United States.*

Optional Information:

Blood Type: _____ Known Allergies: _____

Current Medications: _____

Primary Emergency Contact

Family Name (Surname): _____ First Name: _____

Gender: Male Female Relationship to Student: _____

Language(s) spoken by this contact: _____

Street Address: _____

City: _____ State/Province: _____

Country: _____ Postal Code: _____

Please write the phone numbers as you would dial them from the U.S. (include country codes, area codes, etc).

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Secondary Emergency Contact

Family Name (Surname): _____ First Name: _____

Gender: Male Female Relationship to Student: _____

Language(s) spoken by this contact: _____

Street Address: _____

City: _____ State/Province: _____

Country: _____ Postal Code: _____

Please write the phone numbers as you would dial them from the U.S. (include country codes, area codes, etc).

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Austin Community College, International Student Office, has my permission to release information to my emergency contact(s)/parents, authorized representatives of my government, sponsor, and/or authorized representatives of the United States government.

In the event of an emergency situation involving my death or serious injury, I authorize my emergency contacts to receive medical and other necessary information so they may act on my behalf in such activities as banking, medical decisions, health insurance, billing, etc. I further authorize the International Student Office to obtain and relay to my emergency contacts information about my medical attention.

Student Name: _____
(Please Print)

Signature: _____ Date: _____