



## HEALTH/EMERGENCY CONTACT SHEET

Name \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Health Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_

***Note: Required for enrollment. A copy of insurance card must be attached as proof of current valid coverage.***

The following people should/may be contacted in case of emergency:

1. Family Physician \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

2. Friend/Relative \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

3. Friend/Relative \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

I understand that I must notify Administration of any changes in my insurance and/or the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date