

# LVC Program Emergency Medical Sheet

## Student Information:

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Study Abroad Program: \_\_\_\_\_

Passport Number: \_\_\_\_\_

Passport Date of Expiration: \_\_\_\_\_

## First Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work/Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

## Second Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work/Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Please list any medications you will be taking while on the study abroad program and what medical condition they are treating:**

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**If you have any allergies, please list them here:**

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**Please describe any medical conditions or other circumstances that the program coordinator would need to know before acting in your behalf in a medical emergency:**

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**Health Insurance Provider:** \_\_\_\_\_

**Insurance Policy Identification Number:** \_\_\_\_\_

**Phone/Contact Information for Provider:** \_\_\_\_\_

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**Other needs/issues you would like to share:** \_\_\_\_\_

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