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|--|---|---|---|
| <input type="checkbox"/> North Campus | <input type="checkbox"/> Kendall Campus | <input type="checkbox"/> Wolfson Campus | <input type="checkbox"/> West Campus |
| <input type="checkbox"/> Medical Center Campus | <input type="checkbox"/> Homestead Campus | <input type="checkbox"/> InterAmerican Campus | <input type="checkbox"/> Hialeah Campus |

Emergency Contact Information

This document and its contents constitute a student record and are exempt from public records under §1002.22 and §1006.52, Florida Statutes. The contents of this document can only be disclosed in accordance with the Student's and/or Parent(s)/Guardians consent.

STUDENT NAME

STUDENT NUMBER

Address: _____

E-Mail: _____

Home Phone: _____

Alternate Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Home Phone: _____

Address: _____

E-Mail: _____

Alternate Phone: _____

*Health Insurance Provider: _____

Policy No. _____ Phone: _____

I hereby certify that all of the above information given is true and accurate. I hereby consent to the College disclosing this information for the sole purpose of assessing my/student's medical needs or obtaining medical services on my/student's behalf.

Student's Signature

Date

Parent(s)/Guardian's Signature

Required for students under 18 years of age

Date

*This information shall be only disclosed to a healthcare facility should student require medical services and is unable to personally convey this information to the medical service provider.