

Today's Date: _____

Napa Valley College
Extended Opportunity Programs and Services (EOPS)
EMERGENCY CONTACT AND CURRENT MEDICATION INFORMATION

STUDENT INFORMATION

Last name: _____		Name: _____	
Address: _____		Student ID#: _____	
City: _____		Zip Code: _____	
Home Phone # _____	Cell Phone # _____	Date of Birth: _____	

MEDICAL INSURANCE INFORMATION

Do you have Health Insurance? Yes No
 Insurance Coverage: (Kaiser, Blue Cross, etc..) _____ Coverage #: _____

Physician(s):	Physician's Phone Number:	Pharmacy:	Pharmacy's Phone Number:

EMERGENCY CONTACTS

NAME	RELATIONSHIP	HOME PHONE	MOBILE PHONE	WORK PHONE

MEDICAL & PHYSICAL CONDITIONS(if applicable)

1. _____	2. _____	3. _____
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ALLERGIES TO MEDICATIONS & FOODS (i.e. aspirin, penicillin, milk, etc)

MEDICATION/FOOD	REACTION

CURRENT MEDICATION(s)

MEDICATION	DOSAGE	FREQUENCY	CONDITION / SPECIAL NOTES

AUTHORIZATION / CERTIFICATION

(Please read each statement, initial and sign below)

_____ I certify that the above information is true to the best of my knowledge.

_____ I understand that this information will be provided to medical personnel should an emergency occur, while I am attending an EOPS field trip.

Student Signature

Date