

**University of the Incarnate Word
Office of Residence Life
Emergency Information Form**

Name _____ Date _____

PIDM: _____ Bldg & Room _____

Father's Name _____ Work Ph: _____ Home Ph _____

Address _____

City _____ State _____ Zip Code _____

Mother's Name _____ Work Ph: _____ Home Ph _____

Address _____

City _____ State _____ Zip Code _____

NOTIFY IN CASE OF EMERGENCY:

Name _____ Relationship _____

Work Phone _____ Home Phone _____

Address _____

City _____ State _____ Zip Code _____

Health Insurance Company _____ Phone _____

Name of Policy Holder _____

Policy Number _____

Doctor's Name _____ Phone _____

Please check any allergies, health problems, or physical limitations:

- | | |
|---|---|
| <input type="checkbox"/> Allergies to medications | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Currently taking medications | <input type="checkbox"/> Other _____ |

Please explain any items checked above: _____

Use the back of this form to describe any other physical considerations.

PLEASE RETURN THIS FORM WITH YOUR HOUSING APPLICATION.