LUTHER COLLEGE
at the University of Regina

Emergency Contact Authorization Form

RESIDENT NAME:		
DATE:		
MEDICAL INFORMATION: (Allergies, conditions, special needs, special requests that we should share with emergency/ medical personnel for your best care.)		
CONTACT PERSON 1: (Provide minimum one contact)	Name: Relationship to you: City/Prov/Country: Home Phone: Cell Phone: Work Phone: Email:	
CONTACT PERSON 2: (optional)	Name: Relationship to you: City/Prov/Country: Home Phone: Cell Phone: Work Phone: Email:	

Residents are responsible for having valid medical insurance and carrying medical cards on their person. By signing below, I understand and agree that this document will be in the possession of authorized College personnel and that reasonable care will be taken to keep this information confidential.

___ (initial) I agree to allow Luther College staff to release this information in the event of a medical emergency to a third-party medical provider.

___ (initial) I decline to have Luther College staff release this information to a third-party medical provider in case of a medical emergency.

Resident Signature

Today's Date