



# Emergency Contact Form

Continuing Education & Training  
1601 Washington Road · Westminster, Maryland 21157  
410-386-8100 · FAX 410-386-8111 · Toll Free 1-888-221-9748

*This form must be completed and returned with the application packet*

Student's Name: \_\_\_\_\_

I am registered for: \_\_\_\_\_

Parent/Guardians' Name: \_\_\_\_\_

Mother/Guardian Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Father/Guardian Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Name(s) of Authorized Adult(s) picking up the student:

\_\_\_\_\_

\_\_\_\_\_

1) In an emergency contact:

• Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

• Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2) Health Insurance Company: \_\_\_\_\_

Policy#: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

3) Medical / Health Conditions (e.g. allergies, asthma, physical limitations, etc.):

\_\_\_\_\_

4) Special conditions you would like the instructor to know about: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7) My child has my permission to be photographed, interviewed, or video taped while attending College programs for possible use in marketing:  Yes  No

**I certify the above information to be true and correct to the best of my knowledge and I take responsibility for my child's compliance with the appropriate student behavior. Disruptive and inappropriate behavior may result in dismissal.**

**Parent/Guardian Signature** (required) \_\_\_\_\_