The University *of* Western Ontario
Division of Housing and Ancillary Services

Western

RESIDENT'S EMERGENCY INFORMATION FORM

If you choose to fill out all or part of this document, be advised that the personal information on this form is collected under the authority of the University of Western Ontario Act, 1982, as amended. The information is used to ensure key medical and contact information is available for emergency purposes and will be provided to emergency and/or University personnel as required in the event of an emergency. If you have any questions about this collection, use, or disclosure of personal information, please contact Director of Residences, Elgin Hall, Room 102, The University of Western Ontario, London, ON, N6A 5B9, tel: 519-661-3548.

Surname ____________________ First Name(s) ____________________

Birthdate ______/______/______ (dd mm yyyy)

Residence ____________________

☐ Female ☐ Male

Student Number ____________________

Health Number (provision of health number is voluntary) ____________________

For Office Use Only

Room Number ____________________

Residence Phone Number ____________________

PERMANENT ADDRESS

Address ____________________ City ____________________ Province ____________________

Postal Code ____________________ Phone Number ____________________

Cell Phone Number ____________________ E-mail Address ____________________

EMERGENCY CONTACT

Name ____________________ Relationship ____________________

Address ____________________ City ____________________ Province ____________________ Postal Code ____________________

Home Phone Number ____________________ Work Phone Number ____________________ Cell Phone Number ____________________

ALTERNATE CONTACT

Name ____________________ Relationship ____________________

Home Phone Number ____________________ Work Phone Number ____________________ Cell Phone Number ____________________

MEDICAL INFORMATION (on reverse side) →

MEDICAL INFORMATION

Please note any important physical or mental health issues below.

Medications *(For each of the following, check either "yes" or "no" and specify where necessary.)*

Prescribed Medications ☐ No ☐ Yes ______________________________

____

Are you compliant with the prescription? ☐ No ☐ Yes ☐ Sometimes

Drug Allergies ☐ No ☐ Yes ______________________________

____

Medical Conditions *(For each of the following, check either "yes" or "no". If yes, please indicate if you are under the care of a professional.)*

Serious Allergies ☐ No ☐ Yes ______________________________

Asthma ☐ No ☐ Yes ______________________________

Mental Health Issues ☐ No ☐ Yes ______________________________

Diabetes ☐ No ☐ Yes ______________________________

Epilepsy ☐ No ☐ Yes ______________________________

Other(s) ☐ No ☐ Yes ______________________________

Other Medical Information

____

____

FAMILY PHYSICIAN

______________________________ ______________________________

Name of Physician Address

______________________________ ______________________________

City Province Phone Number

☐ I hereby give The University of Western Ontario my consent to use the information on this form in the event of an emergency, to contact the emergency contact(s) indicated, and to disclose the information to emergency services personnel.

______________________________ ______________________________ ______________________________

Name Signature Date

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