

Student and Emergency Contact Information

Student Last Name: _____ First Name: _____

Parent or Guardian: _____

Address: _____

Home Phone: (____) _____ Daytime Phone: (____) _____

Email: _____

Alternate Contact Person: _____ Relationship: _____

Phone: (____) _____ Daytime Phone: (____) _____

Email: _____

Medical Information

Family Physician: _____

Phone: (____) _____ Medical Health # _____

Does your child currently take any medication prescribed by a doctor? _____ Yes _____ No

If so, please list each medication and the dosage required:

1. _____ Dosage: _____

2. _____ Dosage: _____

If you need more space please use the reverse of this form and indicate that you did so here

Does your child have any ailments or conditions that Mount Allison should know about? (food allergies, injuries, etc.)

If so, please elaborate here:

** Please mail or fax this document to Mount Allison University with you deposit for your registration.*