



# UC Clermont Disability Services Office

## EMERGENCY RESPONSE FORM

Student Name: \_\_\_\_\_

UCID: \_\_\_\_\_

Effective Date: \_\_\_\_\_

### INSTRUCTIONS SPECIFIC TO MY MEDICAL CONDITION:

1. Type of condition: \_\_\_\_\_

2. Side Effects: \_\_\_\_\_

3. Medications taken for this condition: \_\_\_\_\_

4. Best method of assistance: \_\_\_\_\_

5. Preferred hospital if needed: \_\_\_\_\_

6. Emergency Contact: (Name) \_\_\_\_\_

(Phone) \_\_\_\_\_

7. Other: \_\_\_\_\_