

Emergency Contact

Dental Assisting Program



Please fill out completely. Sign at the bottom.

Please list who IHCC should contact in case of an emergency:

Name: _____

Phone number where they can be reached during the day: _____ - _____ - _____

Address or email address: _____

Relationship to you: _____

By signing below, you agree to allow us to contact this person in the case you are involved in an emergency while at campus, in transportation to and from campus, or at your clinical site.

Name: _____

Signature: _____ Date: _____