Medical Information and Release Form

Student Information:

Name: _____

Date of Birth: _____

Home Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Residence Hall: _____ Room Number: _____

Emergency Notification:

Name: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____

Relationship to Participant: _____

Medical Information:

Medical Insurance Company: _____

Insurance Address: _____

Insurance Phone: ( ) _____ Policy Number: _____

Subscriber's Name: _____

Primary Physician: _____ Phone: ( ) _____

Primary Dentist: _____ Phone: ( ) _____

Health Information:

Describe any major illnesses or injuries in the past year: _____

_____

_____

Describe any recurring illnesses, allergies, injuries or reactions that the staff should be aware of:

_____

_____

Describe any medications that may the student may have in his/her possession for treatment of such illnesses, allergies, injuries or reactions: _____

_____

_____

_____ _____

Signature of Participant Date