STUDENT RESIDENCE CENTER MEDICAL INFORMATION

The information requested below is to be kept by the Director of Housing. This form will not become a part of your official records. The purpose of requesting information is to allow the Director of Housing and medical personnel to be of help to you in case an emergency situation were to occur.

PLEASE PRINT

Name: _____
Last First Middle Student ID #

Address: _____
Street & Number City State Zip Code

Your Age: _____ Your Date of Birth: _____ Parent's Phone #: _____

Person to notify in case of emergency: _____
Name

_____
Relationship to Student City State Phone #

Family Physician's Full Name: _____

Physician's Address: _____

1. Blood Type (if known): _____

2. List any medication you are allergic to: _____

_____

3. Any other allergies? _____

_____

4a. Name any disease which you have had, or now have, such as (tuberculosis, seizures, nervous or mental disorders, diabetes, cancer, heart trouble, high blood pressure, ect.) which

you feel may affect you while living on campus or that might require us to assist you.

_____

_____

_____

4b. Are you presently receiving treatment for any of the above? If so please explain.

_____

_____

5. Do you require any services or accommodations for a physical disibility?

_____

_____

6. List any prescription medications which you take regularly.

_____ _____

_____

7. Are you covered by medical/hospitalization insurance? _____

Group #: _____ ID #: _____

8. Any other medical information of which the Director of Housing should be aware?

_____

_____

In the event of illness or accident on campus, I authorize a representative of Vernon College to secure for me the medical attention deemed appropriate by the circumstances and to give the information provided to appropriate hospital/medical personnel.

_____

Student Signature Date

_____

Parent or Guardian Signature Date