

Emergency Information

Please print or type

**Name:** \_\_\_\_\_  
 Last First M.I. Preferred  
**SSN:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Gender:**  Male  Female  
**Phone:** ( ) \_\_\_\_\_ **Name of Parent or Guardian:** \_\_\_\_\_

**EMERGENCY INFORMATION**

**Emergency Contact (parent/guardian)**

Last	First	Home Phone	Work Phone	Cellular Phone
<b>Emergency Contact (parent/guardian)</b>				

Last	First	Home Phone	Work Phone	Cellular Phone
<b>Missing Persons Emergency Contact</b>				

(only if different from above, this name will be called IN PLACE of the above name in the event a student were to become a missing person)

Last	First	Home Phone	Work Phone	Cellular Phone
<b>Missing Persons Emergency Contact</b>				

**INSURANCE INFORMATION**

**Name of Ins. Co.** \_\_\_\_\_  
**Policy/ID No.** \_\_\_\_\_ **Group No.** \_\_\_\_\_ **Plan No.** \_\_\_\_\_

**HEALTH HISTORY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Multiple Sclerosis           |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Mumps                        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Anorexia                | <input type="checkbox"/> Glaucoma or Cataracts | <input type="checkbox"/> Polio                        |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Goiter                | <input type="checkbox"/> Prostate Problems            |
| <input type="checkbox"/> Appendicitis            | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Psychiatric Care or Problems |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Sickle Cell Anemia           |
| <input type="checkbox"/> Bladder problems        | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Stomach Ulcers               |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Strokes                      |
| <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Bulimia                 | <input type="checkbox"/> Major Surgery         | <input type="checkbox"/> Tonsillitis                  |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Measels               | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Chemical dependency     | <input type="checkbox"/> Menstrual Problems    | <input type="checkbox"/> Venereal Disease             |
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Mononucleosis         |   |

Current medication(s): \_\_\_\_\_  
 Current health problems and past health problems: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Explanation of conditions: \_\_\_\_\_  
 Other medical problems: \_\_\_\_\_

**STUDENT TREATMENT CONSENT**

In case of serious illness or accident, I give Tusculum College (or its representatives) permission to secure medical and/or surgical care to include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all costs associated with my medical care.

All statements in this medical record are true to the best of my knowledge and belief. Should any change in my health status occur, I understand Student Affairs should be notified in writing.

Student signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATIONS**

In accordance with HIPAA and other confidential provisions, and in order to provide continued and appropriate medical care, I give Tusculum College or its representatives permission to release personal health information to health care professionals/medical facilities.

Student signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

SSA \_\_\_\_\_