PROVIDENCE
CHRISTIAN COLLEGE

Medical History and Health Form

Part I: Personal

Name _____
(Last Name) (First Name)

Date of Birth _____/_____/_____ Sex: Male ___ Female ___ Age: _____
M D Y

Personal/Family Physician: _____Phone # (____)_____

Address: _____

Person to be notified in case of emergency: _____

Relationship: _____ Phone # (____)_____ (____)_____

Medical Insurance Company _____Policy # _____

Type of coverage (individual or family): _____

* If you are unable to provide proof of health insurance to Providence Christian College you will be required to apply for an individual student health policy through the college.
** Please include with this form a copy of both sides of your insurance card.

Pasadena, CA Area Doctor Information

Name: _____ Phone # (____) _____

Pasadena, CA Area Emergency Medical Center Name:

_____
(Contact your insurance company for the Local Pasadena Area information)

Part II: Medical History (Attach an additional sheet of paper if necessary)

1. Have you ever had (or currently have) any of the following conditions? If yes, please check next to the condition and explain the situation (including the date) in the lines provided.

___Asthma	___Ulcers	___Hearing Problems
___Cancer	___Migraines	___Diabetes/Hypoglycemia
___Eating Disorders	___Mental Illness	___Epilepsy/Convulsions
___Food Allergies	___Kidney Disease	___Thyroid Disease
___Heart Problems	___HIV Positive	___Other

Please explain any conditions marked in question #1:

_____

_____

_____

_____

_____

2. What medical conditions have required care in the past five years, if any? _____

_____

_____

3. What medications are you taking regularly, if any? _____

4. What allergies do you have, if any? _____

5. Have you ever been hospitalized? (if yes, list date and reason) _____

_____

6. Have you ever undergone mental health/emotional counseling? _____

_____

7. Are there any other injuries, diseases, medical conditions, or disabilities that you feel we should be aware? _____

_____

_____

This information will be kept confidential and used only to ensure the health/safety of the student or the college community.

By signing below, I certify that the above information is true to the best of my knowledge. I also certify that the insurance policy information given above will be in force for the entire academic year. I will be personally responsible for the payment of all medical expenses incurred by me or required by the college. I will also immediately notify the college of any change in insurance coverage.

Student Signature _____ Date _____

Parent/Guardian Signature* _____ Date _____

(*Required if student is under 18 years of age)

Return the completed form to:

Office of Student Life
1539 E Howard St
Pasadena, CA 91104

Office Use Only:

Form received by: _____ Date received: _____ Filed by: _____

Scanned into database by: _____ Date scanned: _____