



PROVIDENCE
CHRISTIAN COLLEGE

Medical History and Health Form

Personal Information

Name _____

Date of Birth ____/____/____ Male ____ Female ____ Age: ____

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): _____
(Please include a copy of both sides of your insurance card.)

Pasadena area Doctor Information

Doctor's Name: _____ Phone # (____) _____

Pasadena area Emergency Medical Center Name:

(Contact your insurance company for local Pasadena area information.)

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

Have you ever had (or currently have) any of the following conditions?
Please explain the condition (including applicable dates) in the space provided.

____ Asthma
____ Cancer

____ Ulcers
____ Migraines

____ Hearing Problems
____ Diabetes/Hypoglycemia

___ Eating Disorders
___ Food Allergies
___ Heart Problems

___ Mental Illness
___ Kidney Disease
___ HIV Positive

___ Epilepsy/Convulsions
___ Thyroid Disease
___ Other

Explanation of conditions:

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

What medications are you taking regularly, if any? _____

What allergies do you have, if any? _____

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

Have you ever undergone mental health/emotional counseling? _____

Are there other injuries, diseases, conditions or disabilities we should be aware of?

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 understand that I am required to carry personal medical insurance coverage at all times during my enrollment at Providence Christian College. I will be personally responsible for the payment of all medical expenses incurred by me or required by the college. I will immediately notify the college of any change in my insurance coverage.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

(Required if student is under 18 years of age)

Return completed form to:

Office of Student Life
Providence Christian College
464 E. Walnut St.
Pasadena, CA 91101

Office Use Only

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

Scanned into database by: _____ Date scanned: _____