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	____Ulcers	____Hearing Problems
____Cancer	____Migraines	____Diabetes/Hypoglycemia

____Eating Disorders	____Mental Illness	____Epilepsy/Convulsions
____Food Allergies	____Kidney Disease	____Thyroid Disease
____Heart Problems	____HIV Positive	____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: _____