SEMESTER: ___________

TODAYS DATE: ________ STUDENT MEDICAL INFORMATION FORM

Name: ______________________ K#: __________________ Program: _________________________

Address: ____

Phone: __________________ Cell: __________________

Emergency Contact: ____________________ Phone: ______________ Cell: ______________________

Relationship to patient: ______________________________________

Emergency Contact: ____________________ Phone: ______________ Cell: ______________________

Relationship to patient: ______________________________________

Physician: ____________________ Phone: _______________________ Hospital: _________________

MEDICAL CONDITION: ____

WHEN WERE YOU DIAGNOSED? ____

ANY OTHER MEDICAL HISTORY? ____

____

LIST ANY ALLERGIES: ____

WHAT MEDICINES ARE YOU CURRENTLY TAKING?

1. ________________________ 6. _________________________
2. ________________________ 7. _________________________
3. ________________________ 8. _________________________
4. ________________________ 9. _________________________
5. ________________________ 10. _________________________

WHAT SYMPTOMS SHOULD WE OBSERVE FOR?

____

____

____

____

ARE THERE ANY SPECIFIC DIRECTIONS THE NURSE NEEDS TO KNOW WHEN CARING FOR YOU?

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____
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____
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CURRENT CLASS LIST

Class Time: ___________ **Building** ___________**Rm No.** _________ **Instructor:** ______________________

Class Time: ___________ **Building** ___________**Rm No.** _________ **Instructor:** ______________________

Class Time: ___________ **Building** ___________**Rm No.** _________ **Instructor:** ______________________

Class Time: ___________ **Building** ___________**Rm No.** _________ **Instructor:** ______________________

Class Time: ___________ **Building** ___________**Rm No.** _________ **Instructor:** ______________________

Class Time: ___________ **Building** ___________**Rm No.** _________ **Instructor:** ______________________

All information provided on this form will be kept confidential and locked up in campus health. Information will only be given to the physician you have provided us with or with paramedics and EMT's in the case of an emergency.

SUBMITTING THIS FORM ALLOWS KIRKWOOD CAMPUS HEALTH TO OBTAIN MY EAGLE CARD PHOTO FOR A REFERENCE PHOTO.