



MEDICAL INFORMATION AND RELEASE FORM

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Place of Birth \_\_\_\_\_

Family Doctor's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Please answer the following question:

Are you in good physical condition? Yes \_\_\_ No \_\_\_ If no, please explain condition(s): \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medication? Yes \_\_\_\_\_ No \_\_\_

Medication name, dosages, frequently: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last physical? \_\_\_\_\_

Name of health care professional who performed last physical exam? \_\_\_\_\_

Location where physical was done: \_\_\_\_\_

Special Needs: (check on the line)

\_\_\_\_\_ Hearing Impaired                      \_\_\_\_\_ Visually Impaired                      \_\_\_\_\_ Learning Disability

\_\_\_\_\_ Special Diet                                      \_\_\_\_\_ Physical Disability                                      \_\_\_\_\_ Prosthesis

\_\_\_\_\_ Other: Explain \_\_\_\_\_

In case of a medical emergency, who should we contact?

Name \_\_\_\_\_ Relationship? \_\_\_\_\_

Parent/Guardian telephone number: Home \_\_\_\_\_ Work \_\_\_\_\_

Address \_\_\_\_\_

Significant other, who we may also contact? Name \_\_\_\_\_ Relationship \_\_\_\_\_



Address of significant other: \_\_\_\_\_ Home telephone number \_\_\_\_\_

Work telephone number: \_\_\_\_\_ Other telephone number \_\_\_\_\_

### MEDICAL RELEASE FORM

**I CONSENT TO MEDICAL TREATMENT FOR MY CHILD BY ALABAMA STATE UNIVERSITY HEALTH SERVICES AND/OR LOCAL EMERGENCY SERVICES IF DEEMED NECESSARY BY THE PROGRAM. I UNDERSTAND THAT I WILL BE NOTIFIED OF ANY ILLNESS OR EMERGENCY SITUATION RELATED TO MY CHILD AS SOON AS POSSIBLE AND ACCEPT FULL RESPONSIBILITY FOR ANY UP FRONT CO-PAYMENT AND MEDICAL BILLS THAT MAY RESULT.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

Revised 1/19