RETURN this form to the Office of Residence Life to expedite your Check-In!

Marymount Manhattan College

MEDICAL CONSENT, INSURANCE, AND EMERGENCY FORM

Student's Name: _____ Cell phone: _____

Date of Birth: ____/____/____ Age: _____ Gender: _____

Permanent Address: _____
Street Address

_____
City *State* *Zip* *Home Phone*

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relation to Student: _____

Address: _____

Phone Numbers: *cell:* _____ *home*: _____

AUTHORIZATION FOR CONSENT TO TREATMENT OF A MINOR

(*For all students under the age of 18 years*)
I/We, the undersigned, parent(s)/guardians of (student above), a minor, do hereby authorize medical staff to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act.

_____ _____ _____ _____
Signature & Date Date Signature Date

_____ _____
Phone Number Phone Number

HEALTH INSURANCE

Marymount Manhattan College requires all residential students to have health insurance.

If you have your own insurance:

Name of Insurance Carrier: _____

Policy or Group Number: _____ ID/ Member Number: _____

Expiration Date _____ *(if applicable)*

☐ I will be enrolling in the Student Health Plan, and do not have any Plan details at this time.

PLEASE NOTE: This information is for Residence Life purposes only. To enroll in or opt out of the College Student Health Plan, please visit the Counseling and Wellness Center webpage or call 212.774.0700.

RETURN TO: 221 East 71st St., NY, NY 10021 or residencelife@mmm.edu or fax: 212.517.0665

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MEDICAL HISTORY OF *(student name)*_____

The information on this form will be used when a student needs medical attention and to identify campus resources which may be helpful to the student. It is maintained in the Office of Residence Life. As much as possible, only persons who need to see this information will have access to it. This information is not shared with students' roommates or friends and does not become part of educational records.

1. Are you currently under the care of a health professional? No _____ Yes _____ If yes, for what reason?

_____

2. List all medications you are currently taking:_____

3. List all medications to which you are allergic: _____

4. List any other allergies: _____

5. Check any of the following that you have had, or are subject to at the present time. If any further information is necessary, please use additional sheets.

- o Asthma
- o Alcohol Abuse
- o Attention Deficit Hyperactivity Disorder
- o Bi-polar Disorder
- o Diabetes
- o Digestive Upsets
- o Dizziness
- o Drug Abuse
- o Ear, infection or draining
- o Eating Disorders
- o Encephalitis
- o Epilepsy
- o Fainting/Blackouts
- o Hayfever, recurrent
- o Headaches
- o Head Injury
- o Hearing Difficulty
- o Heart Disease
- o Heart Murmur
- o Hernia/Rupture
- o Hepatitis
- o Infectious Mononucleosis
- o Intestinal Parasite Infection
- o Joints, disease/injury
- o Kidney disease/trouble
- o Leukemia
- o Major Depression
- o Measles
- o Meningitis
- o Menstrual Problems
- o Mumps
- o Ob/Gyn Conditions
- o Paralysis
- o Panic Disorder
- o Pleurisy
- o Pneumonia
- o Polio
- o Psychiatric Hospitalization
- o Psychosis
- o Rheumatic Fever
- o Rubella
- o Scarlet Fever
- o Sinus Trouble
- o Skin Trouble
- o Sore Throats, frequent
- o Swelling of feet/ankles
- o Tonsillitis
- o Tuberculosis
- o Urinary Tract Infection
- o Urinary Difficulty
- o Varicose Veins
- o Visual Difficulty
- o Vomiting, repeated
- o Weight gain
- o Weight Loss

6. Please explain any of those checked above: _____

_____

7. Do you have any other medical problem or disability? (Please describe.)

_____

8. Do you have a clinic or doctor to visit in Manhattan when you are ill? No _____ Yes _____

If yes, please name:_____

9. List any surgical operations or serious accidents you have had with dates:

_____

_____

10. Please describe your general state of health now: _____

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