

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.

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

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: _____