

**KNOX COLLEGE – EMERGENCY/MEDICAL HISTORY INFORMATION – PAGE 1 OF 2**

(Parent/Guardian to complete)

Both pages of this form must be filled out completely, signed, dated, and returned to: Office of Student Development, Knox College, Box K-236, 2 East South Street, Galesburg, IL 61401. All blanks must be completed. If not applicable, indicate the reason (i.e., deceased, divorced, unknown). *Note: Students participating in sports will not be allowed to start practice without this form.*

Name\_\_\_\_\_

Sport (if participating)\_\_\_\_\_

College Address: Campus Box K-\_\_\_\_\_

Date of birth\_\_\_\_\_

Home Address\_\_\_\_\_

Student Cell Phone (\_\_\_\_\_)\_\_\_\_\_

\_\_\_\_\_

Home Phone (\_\_\_\_\_)\_\_\_\_\_

Father/Guardian (circle one)\_\_\_\_\_

Mother/Guardian (circle one)\_\_\_\_\_

Father/Guardian Date of Birth\_\_\_\_\_

Mother/Guardian Date of Birth\_\_\_\_\_

Address\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Work Phone (\_\_\_\_\_)\_\_\_\_\_

Work Phone (\_\_\_\_\_)\_\_\_\_\_

Father/Guardian Insurance Co.\_\_\_\_\_

Mother/Guardian Insurance Co.\_\_\_\_\_

Family or single coverage? (circle one)

Family or single coverage? (circle one)

Insurance Effective Date\_\_\_\_\_

Insurance Effective Date\_\_\_\_\_

Ins. Address\_\_\_\_\_

Ins. Address\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Policy/Group No.\_\_\_\_\_

Policy/Group No.\_\_\_\_\_

Phone (\_\_\_\_\_)\_\_\_\_\_

Phone (\_\_\_\_\_)\_\_\_\_\_

Is there any other policy that may cover this student? Yes\_\_\_\_\_ (Please provide info as above on a separate sheet.) No\_\_\_\_\_

For insurance that covers the student:

Is the plan either of the following? HMO\_\_\_\_\_ PPO\_\_\_\_\_ No\_\_\_\_\_

Does your insurance plan require a second opinion before surgery? Yes\_\_\_\_\_ No\_\_\_\_\_

Does your insurance plan cover athletic injuries? Yes\_\_\_\_\_ No\_\_\_\_\_

Policy Deductible \$\_\_\_\_\_ Policy Limit \$\_\_\_\_\_ Policy Co-Pay \$\_\_\_\_\_

**PLEASE INCLUDE COPIES (front and back) OF ANY INSURANCE CARDS THAT COVER THE STUDENT.**

I hereby authorize my insurance company, prepayment organization, employer hospital, physician, pharmacy clinic or any other organization to release all information to Knox College and related insurance companies with respect to the above named student which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information is true and correct. A copy of this authorization shall be as valid as the original. I authorize that the insurance agent pay the medical vendors direct for any bills incurred from accidents or sickness that are covered under the Knox College policy.

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

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

Date\_\_\_\_\_

**KNOX COLLEGE – EMERGENCY/MEDICAL HISTORY INFORMATION – PAGE 2 OF 2**

(Parent/Guardian to complete)

Please complete both pages of this form and return to the  
Office of Student Development, Knox College, Box K-236, Galesburg, IL 61401 or fax: 309-341-7077.  
(The following information may be utilized in the event of an emergency. This information does not  
become a part of any medical file utilized for routine care at the Knox College Health Center.)

Name of Student \_\_\_\_\_

Emergency contact (other than parent/guardian) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

1. Please list any pre-existing medical conditions (i.e., asthma, anemia, diabetes, epilepsy): \_\_\_\_\_

\_\_\_\_\_

2. Please list any significant illnesses in the last two years (i.e., mononucleosis, hepatitis, flu): \_\_\_\_\_

\_\_\_\_\_

3. Has there been any loss of bodily organs (i.e., kidney, appendix)? If so, please list: \_\_\_\_\_

\_\_\_\_\_

4. Is there any history of head injury and/or concussion? If so, please provide dates, nature of injury and treatment: \_\_\_\_\_

\_\_\_\_\_

5. Please list any known drug, food, and/or insect bite allergies: \_\_\_\_\_

\_\_\_\_\_

6. Please list any medication taken on a regular basis, amount taken and the purpose for taking the medication: \_\_\_\_\_

\_\_\_\_\_

7. Please list any pre-existing orthopedic conditions and describe the nature of the injury, any appliances worn and any  
rehabilitation currently being under taken: \_\_\_\_\_

\_\_\_\_\_

8. Do you ever have abnormal shortness of breath during physical activity? \_\_\_\_\_

\_\_\_\_\_

9. Please list and explain any known family history of diabetes, high blood pressure, heart trouble, epilepsy, etc. \_\_\_\_\_

\_\_\_\_\_

10. Please list any dental injuries, work performed and/or any special appliances worn: \_\_\_\_\_

\_\_\_\_\_

11. Do you wear contacts? \_\_\_\_\_ Do you wear glasses? \_\_\_\_\_

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

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

Date \_\_\_\_\_