

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 _____