KNOX COLLEGE

OFFICE OF STUDENT DEVELOPMENT
309-341-7863 Phone
309-341-7077 Fax
www.knox.edu

Emergency Medical History Information

Please fill out this form completely (all blanks must be completed) and return the signed and dated copy to Office of Student Development, Knox College, Box K-236, 2 East South Street, Galesburg, IL 61401 or fax to 309-341-7077. If something is not applicable, indicate the reason, (i.e., deceased, divorced, unknown). **Note: Students participating in sports will not be allowed to start practice until this form has been received.**

STUDENT INFORMATION

Name _____ Student ID#_____
Last First Middle (Returning students only)

Date of birth_____ /_____ /_____ Sport (if participating) _____
month day year

Home address (Street) _____

City, State, Zip _____

Home phone (_____)_____ Cell phone (_____)_____ Campus Box K-_____

PARENT/GUARDIAN INFORMATION

Father/Guardian (circle one)

Name _____

Date of birth_____ /_____ /_____
month day year

Address (if different from above) _____

City, State, Zip _____

Work phone _____

Insurance company_____

Family or single coverage? (circle one)

Insurance effective date _____

Insurance address _____

_____

Policy/Group number _____

Insurance phone (_____) _____

Mother/Guardian (circle one)

Name _____

Date of birth_____ /_____ /_____
month day year

Address (if different from above) _____

City, State, Zip _____

Work phone _____

Insurance company_____

Family or single coverage? (circle one)

Insurance effective date _____

Insurance address _____

_____

Policy/Group number _____

Insurance 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 cover athletic injuries? Yes_____ No_____

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.

Signature of Parent/Guardian _____

Signature of Student_____ **Date** _____

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The information on this side of the form will only be utilized in the event of an emergency. In order to provide the best care for your student, it is important that you provide all of the information below.

Name of student _____
Last First Middle

Emergency medical 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. Please list and explain any known family history of diabetes, high blood pressure, heart trouble, epilepsy, etc. _____

_____

9. Please list any dental injuries, work performed and/or any special appliances worn _____

_____

10. Does the student wear contacts? _____ Does the student wear glasses? _____

I understand that the information above will be utilized by Knox College only in the event of an emergency. This information is not being authorized for any other use and will not become part of any medical file utilized for routing care at the Knox College Health Center.

Signature of Parent/Guardian _____

Signature of Student _____ **Date** _____