# North Carolina Association of Student Councils

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## HEALTH INFORMATION FORM

***BRING THIS COMPLETED FORM WITH YOU TO REGISTRATION. DO NOT MAIL IN ADVANCE.***

### *PERSONAL INFORMATION*

PRINT STUDENT NAME

STREET ADDRESS — DATE OF BIRTH / /

CITY, STATE, ZIP — Age

HOME/CELL PHONE — GENDER

### *EMERGENCY INFORMATION*

PARENT / GUARDIAN NAME — PHONE 1 ( )

PHONE 2 ( )

IFPARENT / GUARDIAN CAN NOT BE REACHED — PHONE 1 ( )

PHONE 2 ( )

PHYSICIAN NAME — PHONE ( )

### *MEDICAL PAYMENT & INSURANCE INFORMATION*

****NOTE: PLEASE ATTACH A PHOTOCOPY OF THE INSURANCE CARD*

PERSON RESPONSIBLE FOR MEDICAL PAYMENT — PHONE ( )

DOES STUDENT HAVE MEDICAL INSURANCE? YES / NO — IF YES, NAME OF INSURANCE COMPANY

NAME OF INSURED

CUSTOMER SERVICE PHONE # — ID #

STREET ADDRESS OF INSURANCE COMPANY — GROUP#

CITY, STATE, ZIP

### *BRIEF MEDICAL HISTORY*

| | | |
|---|---|---|
| ASTHMA | YES / NO | MEDICATIONS |
| DIABETES | YES / NO | MEDICATIONS |
| EPILEPSY/SEIZURES | YES / NO | MEDICATIONS |
| HEART | YES / NO | MEDICATIONS |
| OTHER HEALTH CONCERNS | YES / NO | IF YES, PLEASE LIST |
| SHOULD ACTIVITY BE RESTRICTED? | YES / NO | IF YES, PLEASE EXPLAIN |
| ANY MEDICAL ALLERGIES? | YES / NO | IF YES, PLEASE LIST |

CURRENT MEDICATION & DOSING INSTRUCTIONS

**NOTE: IF STUDENT IS BRINGING MEDICATION, PLEASE BRING A SUPPLY IN A LABELED CONTAINER*

I, the parent or legal guardian of _____, authorize and direct the North Carolina Association of Student Councils (NCASC) to obtain medical care for my child in the event such care is reasonably necessary. I understand that, if possible I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any reasonably necessary medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment of such care. I release NCASC, its employees, and agents from any damages, liability, or loss resulting from the discretion in securing in good faith medical care for my child.

PARENT / GURDIAN SIGNATURE — DATE