MANSFIELD UNIVERSITY MUSIC DEPARTMENT
HEALTH RECORD

Student's Name _____
Last First M. I.

Birth Date ____/____/____ Age _____ Sex M F

Parents/Guardian _____

Address _____

_____

Phone (____) _____ (____) _____

(____) _____ (____) _____

Pertinent Medical History _____

_____

List of Current Medications/Dose/Time _____

_____

Allergies _____

Last Date of Tetanus Toxoid _____

Name of Insurance Company _____ Policy # _____

Address of Insurance Company _____

_____

Other person(s) to be notified in case of accident or illness if parent/guardian is not at home:

_____ (____) _____
Name Phone

_____ (____) _____
Name Phone

I give Mansfield University permission to treat myself or my son/daughter in the case of an accident and/or illness.

_____ ____/____/____
Signature Date