HEALTH RECORD

Student's Name _____Birth Date: _____ Age:_____ Sex: M F
Last First M.I.

Parents or Guardian:_____ Address:_____

Phone_____

Emergency Contact Email Address (if available): _____

Pertinent Medical History:_____

List Current Medications/ Dose/Time: _____

Allergies:_____

Last Date of Tetanus Toxoid:_____ Name of Insurance Company: _____

Policy # _____ Address of Insurance Company:_____

Other person to be notified in case of accident or illness if parent is not at home:

_____
Name Phone

I give Mansfield University permission to treat my son/daughter for accident and/or illness. Signature needed only if the above named is under 18 years of age.

_____
Signature Date

I give Mansfield University permission to treat me for accident and/or illness in the event I am incapacitated and cannot speak for myself in an emergency situation.

_____
Signature Date