

**MISSOURI ASSOCIATION OF STUDENT COUNCILS  
STATE CONVENTION  
HEALTH INFORMATION FORM**



**BRING THREE COPIES OF 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 \_\_\_\_\_

SSN OF STUDENT \_\_\_\_\_

HOME/CELL PHONE \_\_\_\_\_

GENDER \_\_\_\_\_

**EMERGENCY INFORMATION**

PARENT / GUARDIAN NAME \_\_\_\_\_

PHONE 1 (        )

PHONE 2 (        )

IF PARENT / GUARDIAN  
CAN NOT BE REACHED \_\_\_\_\_

PHONE 1 (        )

PHONE 2 (        )

PHYSICIAN NAME \_\_\_\_\_

PHONE (        )

**MEDICAL PAYMENT & INSURANCE INFORMATION**

PERSON RESPONSIBLE FOR  
MEDICAL PAYMENT \_\_\_\_\_

PHONE (        )

DOES STUDENT HAVE  
MEDICAL INSURANCE? \_\_\_\_\_

YES / NO

IF YES, NAME OF  
INSURANCE COMPANY \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

SSN OF INSURED \_\_\_\_\_

CUSTOMER SERVICE PHONE # \_\_\_\_\_

ID # \_\_\_\_\_

STREET ADDRESS OF  
INSURANCE COMPANY \_\_\_\_\_

GROUP # \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

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

**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 TO CONVENTION, PLEASE BRING A SUPPLY IN A LABELED CONTAINER*

I, the parent or legal guardian of \_\_\_\_\_, authorize and direct the Missouri Association of Student Councils (MASC) 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 MASC, 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 / GUARDIAN  
SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_