

**MISSOURI ASSOCIATION OF STUDENT COUNCILS
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 _____

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

****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 _____

SSN 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 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 / GURDIAN
SIGNATURE _____

DATE _____