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 ( )

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 | 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