

SEMESTER: \_\_\_\_\_

TODAYS DATE: \_\_\_\_\_ STUDENT MEDICAL INFORMATION FORM



Name: \_\_\_\_\_ K#: \_\_\_\_\_ Program: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

MEDICAL CONDITION: \_\_\_\_\_

WHEN WERE YOU DIAGNOSED? \_\_\_\_\_

ANY OTHER MEDICAL HISTORY? \_\_\_\_\_

LIST ANY ALLERGIES: \_\_\_\_\_

**WHAT MEDICINES ARE YOU CURRENTLY TAKING?**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**WHAT SYMPTOMS SHOULD WE OBSERVE FOR?**

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ARE THERE ANY SPECIFIC DIRECTIONS THE NURSE NEEDS TO KNOW WHEN CARING FOR YOU?

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**CURRENT CLASS LIST**

Class Time: \_\_\_\_\_ Building \_\_\_\_\_ Rm No. \_\_\_\_\_ Instructor: \_\_\_\_\_

Class Time: \_\_\_\_\_ Building \_\_\_\_\_ Rm No. \_\_\_\_\_ Instructor: \_\_\_\_\_

Class Time: \_\_\_\_\_ Building \_\_\_\_\_ Rm No. \_\_\_\_\_ Instructor: \_\_\_\_\_

Class Time: \_\_\_\_\_ Building \_\_\_\_\_ Rm No. \_\_\_\_\_ Instructor: \_\_\_\_\_

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Class Time: \_\_\_\_\_ Building \_\_\_\_\_ Rm No. \_\_\_\_\_ Instructor: \_\_\_\_\_

All information provided on this form will be kept confidential and locked up in campus health. Information will only be given to the physician you have provided us with or with paramedics and EMT's in the case of an emergency.

**SUBMITTING THIS FORM ALLOWS KIRKWOOD CAMPUS HEALTH TO OBTAIN MY EAGLE CARD PHOTO FOR A REFERENCE PHOTO.**