Emergency Information Card 2014–15 Student Health Center

Name ______________________________ Student ID no. ______________________

Date of birth ______________ Home phone ______________ Cell phone ______________

Home address ____
Street City, State ZIP

In case of emergency, contact ____

Home phone ______________ Cell phone ______________ Relationship ______________

Father's name ______________ Home phone ______________ Cell phone ______________

Mother's name ______________ Home phone ______________ Cell phone ______________

Medical conditions (asthma, diabetes, seizure disorder, etc.) ______________________________

____

Daily medications, medical devices, etc. ______________________________________

Allergies ____

Insurance company ______________________________ Policy no. ______________________

Address ______________________________ City and state ______________________

Insured's name ______________________________ Phone ______________________

Insured's date of birth ______________ Doctor's name ______________ Phone ______________

Parental Authorization for Treatment

If your student will be under the age of 18 at the beginning of the semester, we need your authorization for any medical treatment that may be required. Please sign the statement below and return this form to the Student Health Center at the address provided.

I, ______________________, am the parent or legal guardian of ______________. I hereby give my consent to any provider at the Azusa Pacific University Student Health Center for any medical and/or psychological treatment that is deemed necessary for my child named above.

Signature of parent or legal guardian ______________________________ Date ______________

PLEASE RETURN THIS FORM TO:

Student Health Center
Azusa Pacific University
PO Box 7000, Azusa, CA 91702-7000

Phone (626) 815-2100
Fax (626) 815-2102
apu.edu/healthcenter

15145