Global Student Success Program Emergency Medical Consent Form

Richard Bland College of WILLIAM & MARY
GLOBAL STUDENT SUCCESS PROGRAM

Personal details

Name must appear exactly as it is in the applicant's passport.

Last name:	First name:
Date of birth: DAY / MONTH / YEAR	
Gender: ☐ Male ☐ Female ☐ Transgender	
Student ID #:	
Home Phone:	Mobile Phone:
Email Address:	

Contact details

Permanent Address
Country of birth:
Date entering RBC: DAY / MONTH / YEAR

Parent/Guardian/Next-of-Kin Information (in case of emergency)

Name:	
Relationship to student:	
Permanent Address:	
Home Phone:	Mobile Phone:

Only in the event of an emergency would this contact information be released to College Authorities

Primary Care Provider

Name:
Business Phone:

Insurance Coverage

Name of Company:
Address:
Subscriber Name:
Subscriber ID#:

Consent for Medical Care

If student is under 18 years of age, a parent or guardian must also sign this consent form. This form will be valid until student turns 18.

I hereby grant permission to the Director of Richard Bland College of William & Mary Health Services, or authorized representatives to provide such medical care as my daughter/son/ward:

Name of student:

may require while he/she is a student at Richard Bland College of William & Mary, including examinations, treatment, immunizations, etc. This also includes referral to an outside provider, a local hospital, hospitalization, anesthesia and/or surgery should be necessary in the event of a serious illness or injury and I am unable to be reached.

Parent's/guardian's signature:
Date: DAY / MONTH / YEAR

Medical Health History Form

Last name:	First name:
Date of birth: DAY / MONTH / YEAR	Student ID #:

Family History

	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Spouse				
Children				

Have any of your immediate relatives had any of the following:

	Yes	Relationship
Alcohol/Substance Abuse		
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Neuromuscular Disorder		
Mental Illness		
Tuberculosis		

Personal History (do you have now or have you ever had any of the following): CIRCLE ALL THAT APPLY

Anemia	Deaf/hearing impairment	Impaired mobility/paralysis Irritable Bowel Syndrome	Pneumothorax	Other:
Anorexia Nervosa/Bulimia	Depression	Kidney disease/stones	Seizure disorder	
Appendectomy	Diabetes	Learning disability	Sickle cell disease	
Arthritis	Drug/Alcohol problems	Loss of paired organ (eye, kidney)	Sleep Problems	
Asthma	Emotional/mental illness	Malaria	Thyroid disease	
Blind/visual impairment	Heart disease/problem	Migraines/chronic headaches	Positive TB test	
Cancer/malignancy	Hepatitis (Type _____)	Mononucleosis	Tuberculosis disease	
Chickenpox	High Blood Pressure	Neuromuscular disease	Ulcer/stomach problems	
Crohn's/Ulcerative Colitis	High cholesterol	Phlebitis/deep vein clot	Urinary tract infection (frequent/recurrent)	

Please explain all positive answers (with dates):
Inpatient Hospitalizations: Please list all medical/psychiatric hospitalizations, dates, and diagnoses:
Medications: Please list all (prescription and over-the-counter) including birth control and herbal supplements:
Allergies: ☐ Yes ☐ No ☐ Unknown (If yes, please specify, including medications, insect venoms, foods, etc.) and type of reaction: