ADELPHI UNIVERSITY

PRE-COLLEGE PROGRAM STUDENT HEALTH AND EMERGENCY FORM 2017
PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE OFFICE OF HIGH SCHOOL AND PRE-COLLEGE PROGRAMS BY JUNE 15, 2017.

PLEASE PRINT. (All information is required and all entries must be written in English.)

Family name/surname _____ First/given name _____ MI _____

Nickname _____

Home address _____
Street Apt. City State Postal code

Social Security no. _____ Date of birth _____

Student home phone ( ) _____ Student cellphone ( ) _____

Student email _____

Parent email _____

EMERGENCY CONTACT

Father's name _____ Work phone no._____ Cellphone no._____

Mother's name _____ Work phone no._____ Cellphone no._____

Please provide contact information for individuals local to Garden City, New York, and who can travel to campus in an emergency.

First emergency phone contact, notify _____ Phone no._____

Second emergency phone contact, notify _____ Phone no._____

Parent/guardian will be out of the country during the time the program is in session? ☐ Yes ☐ No

FAMILY HEALTH INSURANCE INFORMATION*

Name of insured _____Relationship to participant _____

Insurance company_____Group no._____

Policy number_____Member ID no._____

Primary healthcare provider name_____

Phone no._____Fax no._____

Address_____

***Please provide a copy of front and back of insurance card(s) and pharmacy prescription card(s)**.

Adelphi University is not qualified to administer medications to any participant. The participant should be capable of self-administering the medication(s) or schedule the dose for before arrival or after departure.

Health insurance is mandatory for all resident and international students. To learn about the requirements and waiver process, visit **students.adelphi.edu/sa/hs/insurance.php**.

CONSENT FOR MEDICAL TREATMENT OF MINORS (students under the age of 18):

To provide medical evaluation or treatment to students under the age of 18, parental permission is necessary by law. All students younger than 18 years old require a parent's or guardian's signature submitted to the Health Services Center for medical treatment consent.

I hereby grant permission for medical evaluation, treatment and hospitalization in case of accident or illness for my minor child/legal ward. I also give permission for the release of information concerning his or her medical condition to other responsible University officials when necessary, or to outside agencies for treatment on an as-needed basis.

Signature of parent/guardian _____ Date _____

ADELPHI UNIVERSITY

Family name/surname _____ First/given name _____ MI _____

SECTION 1

Drug allergies _____ Food allergies or intolerance _____

Does student require EpiPen? ☐ Yes ☐ No Has student been trained in its use? ☐ Yes ☐ No ☐ NA _____

Medications (Please include prescription medications and any over-the-counter medications taken daily.):

_____

Past medical history _____

_____

Family medical history _____

_____

This form must be returned to the Office of High School and Pre-College Programs,
Hagedorn Hall, Room 201, One South Avenue, P.O. Box 701, Garden City, NY 11530-0701, USA
or faxed to 516.877.3424.