Gallaudet University Student Health Service Form

Last Name_____First Name_____ Date of Birth _____

Place of birth (city) _____ State_____ Country_____

Street Address_____ City_____ State____ Zip Code _____

Home/Cell #_____Student ID_____ Email _____Circle Male/Female/Transgender

List below Names, addresses, phone #'s of (2) people to be notified in case of an emergency

Name:_____Name:_____

Street Address#_____Street Address#_____

City, State, Zip_____City, State, Zip _____

Home/Cell #_____Home/Cell #_____

Email_____Email_____

Authorization for Medical Treatment: No Medical Treatment will be given if not signed

I certify that the foregoing information is true and complete to the best of my knowledge. I also realize that the information I have given in the medical history section is confidential and for the use of the attending medical staff. I realize that my signature gives the Student Health Service permission to forward my name to the Office for Students with Disabilities, if I have checked "Yes" below.

I give permission to Gallaudet University to provide diagnostic, therapeutic, and operative procedures, voluntary immunizations, and transportation, as may be deemed necessary by its medical staff on my behalf. I am 18 years or older.

Student Signature_____Date_____

Permission for Treatment of Minors

I authorize Gallaudet University Student Health Service to obtain medical information from another medical facility on my behalf for continuity of care

Signature of Parent/Guardian_____Date_____

This consent form is to be signed by the parent or legal guardian of minors (under 18 years of age) so that the appropriate diagnosis and treatment may be promptly carried out without unnecessary delays that may occur with emergency health service procedures. No major health services will be performed except in an emergency, without the permission of the parent or legal guardian being contacted and fully informed. Transportation to area hospitals or diagnostic centers will be the responsibility of the parent or legal guardian

Signature of parent or legal guardian_____Date_____

Insurance Billing Authorization

I hereby given my permission for the Student Health Service to release any and all information related to processing health insurance claims and obtaining payment for medical bills to the appropriate physicians, hospitals, laboratories, insurance agencies, parents/legal guardians, or any other agents as necessary including University personnel

Signature student, parent or legal guardian_____Date_____

The Student Health Service works in cooperation with the Office of Students with Disabilities. May Student Health Service refer your name and medical information regarding your disability to the Office of Students with Disabilities? Yes_____NO____