



CONCORDIA
UNIVERSITY

MEDICAL INFORMATION FORM

PLEASE PRINT

Name: _____
Last First Middle Initial

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of Birth: _____ Current Phone # _____

In Case of Emergency, Notify: _____

Phone Number: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Physician's Name : _____ Phone # _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company : _____ Policy # _____

Address: _____

City: _____ State: _____ Zip: _____

Please Check if Applicable:

Diabetes: Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Oral <input type="checkbox"/> Insulin			
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Cancer (Kind: _____)			
<input type="checkbox"/> Bleeding Trait (Kind: _____)			
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Lupus	
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Connective Tissue Disease		

Allergy to medications: _____

Allergy to food, pollen and other: _____

If currently on prescription medication, specify: _____

Any additional information (physical impairment/handicaps, etc.: _____

Signature Date Parent/Guardian signature-if under 18 years of age