Meridian Community College
STUDENT HEALTH AND EMERGENCY INFORMATION

Name_____
Last First Middle (full middle name)
Address_____
No. Street Tow Zip code
Home Phone _____ Gender _____Date of Birth_____
Language spoken at home _____Place of Birth_____
Does child have health insurance? Yes _____No_____
Provider_____ Policy ID _____
Parent 1/Guardian name (print) _____
Home
Address_____
Home Phone _____Work Phone_____
Cell Phone_____Pager_____
Parent 1
Signature_____
Parent 2/Guardian name (print) _____
Home
Address_____
Home Phone _____Work Phone_____
Cell Phone_____Pager_____
Parent 2 Signature_____

IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED, PLEASE LIST NAME AND PHONE NUMBER OF RELATIVE OR FRIEND WE MAY CONTACT.

EMERGENCY NAME_____ Relationship_____
Home Phone _____ Work Phone_____ Cell Phone_____
Physician's Name_____Phone_____
Dentist's Name_____Phone_____
Hospital of Choice_____ (EMT or Paramedic may override choice)

Please check all that applies to your child:

Heart
condition_____Diabetes_____Asthma_____SeizureDisorder_____ADD/ADHD_____Migraines_____
Depression_____
Other (specify) _____
Allergies (food, insects medication, environment, (specify) _____
Does your child have an EpiPen? Yes_____ No_____
Hearing Problems (specify) right ear _____left ear_____
Vision Problems (specify) _____

Documentation of the students MMR must accompany this form and must be on file with our office prior to check in.

I give permission to the MCC Housing Staff to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral diagnosis and treatment.

Parent/Guardian
signature_____Date_____

I give permission to the MCC Housing Staff to share information relevant to my health condition with appropriate school personnel when needed to meet my health and safety needs. I give permission to exchange information with my primary care physician for the purpose of referral diagnosis and treatment.

Student
signature_____Date_____