ACC ALVIN COMMUNITY COLLEGE

Student Accessibility Services

Medical Information Form

Completion of this form is needed to serve you in case of a medical emergency. This form will be on file with Campus Police and Student Accessibility Services. Information is released to pertinent individuals at the student's request. All information will be kept strictly confidential. ***The student is responsible for updating all information, as necessary to ensure consent and contact information accuracy.***

Name: _____ Student ID #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Mobile Phone: _____ Home Phone: _____

Email address: _____

Condition: ☐ **Diabetes** ☐ **Asthma** ☐ **Seizures** ☐ **Severe Allergic Reaction** ☐ **Physical** ☐ **Medical**

Brief Description / Special Needs: _____

_____

Emergency Contacts (in order of expected contact):

1. Name: _____ Relationship: _____

   Mobile Phone: _____ Home Phone: _____

2. Name: _____ Relationship: _____

   Mobile Phone: _____ Home Phone: _____

3. Name: _____ Relationship: _____

   Mobile Phone: _____ Home Phone: _____

4. Name: _____ Relationship: _____

   Mobile Phone: _____ Home Phone: _____

Student Signature: _____ Date: _____

ACC Alvin Community College

Student Accessibility Services

First Name: _____ Last Name: _____ Student ID #: _____

Disability Diagnosis / Description: _____ ☐ Permanent or ☐ Temporary

*****If seizure disorder please attach instruction sheet*****

Allergies (*known / expected effects*)**: ☐ Medication ☐ Food ☐ Other: _____**

Relevant Medication(s): _____

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be contacted:

Doctor: _____Phone: _____

Specialist: _____Phone: _____

Doctor's Office, Local Hospital, or Emergency Room preference:

_____ Phone: _____

I hereby give my consent for: 1) the administration of any treatment deemed necessary by above named doctors, or by another licensed physician (*in the event the designated practitioner is not available*); and 2) the transfer to the designated facility, or any hospital reasonably accessible.

Student Signature: _____

Witness: _____

Date: _____

Part II: REFUSAL OF CONSENT

I do **NOT** give my consent for emergency medical treatment of any kind. In the event of illness or injury requiring emergency treatment, I wish authorities to take the following action(s):

_____

_____

_____

_____

_____

Student Signature: _____

Witness: _____

Date: _____