

# Clark University Medical Record

Office Use Only:  
History Reviewed: \_\_\_\_\_

## PART A -- HEALTH HISTORY

Please print or type

Students who do not submit a complete medical record (parts A, B & C) will not be permitted to register.

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
MONTH DAY YEAR

UNIVERSITY STATUS: Circle Entering Class: Fr. So. Jr. Sr. Gr. Entrance Date: \_\_\_\_\_

- Name: \_\_\_\_\_
- Male:  Female:  Single:  Married:  Other:
- Are you adopted? Yes:  No:
- Home Address: \_\_\_\_\_  
Number and Street City State Zip Code  
Home Telephone Cell Phone E-mail

- Parent or Guardian: \_\_\_\_\_  
Home Address (Area Code) Telephone  
Business Address (Area Code) Telephone

- Parents: Married:  Widowed:  Separated:  Divorced:
- Alternate responsible person (cannot be same household as No. 5 above) to be contacted in case of emergency if Parent or Guardian unavailable.

**REQUIRED**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ (Area Code) Telephone: \_\_\_\_\_

- Will you be enrolled in Clark's student health insurance Plan? Yes:  No:   
If "No," what plan will you be covered under for this academic year?

Plan Subscriber ID# Group Number

\* Please attach a copy of both sides of your insurance card.

Family History	Age	State of Health	Occupation	Year of Death	Cause of Death	Has anyone in your immediate family had any of the following?	Yes	No	Relationship
Father						1. Alcoholism			
Mother						2. Bleeding Disorder			
Brothers						3. Diabetes			
						4. Epilepsy/Convulsion			
						5. Emotional Disorder			
Sisters						6. Heart Attack before 60			
						7. Heart Disease			
						8. High Blood Pressure			
Spouse						9. Kidney Disease			
Children						10. Stroke			
						11. Breast Cancer			
						12. Other Cancer			

Give Details of above: \_\_\_\_\_

**Consent for treatment (required for students under 18):**

I hereby give consent for my minor child \_\_\_\_\_ to receive routine care through the Clark University Health Service and, in the event of an EMERGENCY, give permission to the Health Service and its affiliated hospital to secure for this child appropriate treatment, including orders for surgery and anesthesia if necessary.

**Consent for treatment (students over 18):**

In the event of an EMERGENCY, I hereby give permission to Clark University Health Service and its affiliated hospital to secure for me appropriate treatment, including orders for surgery and anesthesia if necessary.

Signature of Parent or Guardian

Print name of Parent or Guardian

Signature of Student (over 18)