

**EMERGENCY HEALTH FORM**

This information will be kept on file in the Office of Admissions to be used in the event of an emergency. You are not obligated to answer any of these questions. Please return this form to the Office of Admissions, Records, and Registration.

- 1. NAME \_\_\_\_\_
- 2. STUDENT NUMBER \_\_\_\_\_
- 3. ADDRESS \_\_\_\_\_  
\_\_\_\_\_
- 4. TELEPHONE—HOME \_\_\_\_\_ BUSINESS \_\_\_\_\_
- 5. PARENTS OR SPOUSE'S NAME \_\_\_\_\_
- 6. ADDRESS \_\_\_\_\_
- 7. FATHER'S PLACE OF EMPLOYMENT \_\_\_\_\_
- 8. MOTHER'S PLACE OF EMPLOYMENT \_\_\_\_\_
- 9. FAMILY PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

9. DO YOU HAVE ANY MEDICAL CONDITIONS OF WHICH THE COLLEGE SHOULD BE AWARE? YES \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Allergies: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Diabetes: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Epilepsy: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Physical Handicap: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Are you presently on any prescribed drugs or medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list them \_\_\_\_\_

In the event of an emergency, I authorize the above named physician to release any medical information that may be necessary to Bucks County Community College.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_