

## Medical Reference

### *APPLICANT INFORMATION*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone Number (\_\_\_\_\_) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Employer Name and Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Employer Name and Phone: \_\_\_\_\_

### *EMERGENCY INFORMATION*

**In case of illness or injury and parent cannot be reached, please call:**

Name	Phone Number	Relationship
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Name	Phone Number	Relationship
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### *PERSONAL PREFERENCE*

Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Preferred Hospital (in San Antonio): \_\_\_\_\_ Phone Number: \_\_\_\_\_

#### **Vaccinations:**

\*You need to present a copy of your shot record before your acceptance

MMR Date: \_\_\_\_\_  Polio Date: \_\_\_\_\_

Meningitis Date: \_\_\_\_\_  TB Skin Test Date: \_\_\_\_\_

#### **Do you or have you had any of the following conditions:**

\_\_\_ Convulsion \_\_\_ Diabetes \_\_\_ Visual Problem \_\_\_ Heart Problem \_\_\_ Hearing Problem

\_\_\_ Orthopedic Disability \_\_\_ Speech Problem

Other (please explain): \_\_\_\_\_

Do you have any special dietary needs? If so, please explain. (Use an additional sheet of paper if necessary)

Do you have any allergies? If so please explain. (Use an additional sheet of paper if necessary)

Do you take medication on regular basis? If so explain (Use an additional sheet of paper if necessary)



Christ Mission College does not assume any financial responsibility, but does wish to provide the best emergency service. By signing this form you are giving appropriate authority to call EMS or obtain medical care in case that your parent or the alternate adult cannot be reached. Note: If you are under 18 years of age this form must be signed by a parent or legal guardian.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_