





**PART III. PERSONAL INFORMATION**

Parent's or guardian's name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Father's place of employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Mother's place of employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Family physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Health insurance policy information. Insurance carrier \_\_\_\_\_**

Contract No. \_\_\_\_\_ (Street address) \_\_\_\_\_  
Group No. \_\_\_\_\_ (City, state, ZIP) \_\_\_\_\_  
Subscriber's name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
Subscriber's DOB \_\_\_\_\_

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**PART IV. MEDICAL HISTORY**

Current medical/psychological concerns \_\_\_\_\_  
\_\_\_\_\_

Past medical/psychological concerns \_\_\_\_\_  
\_\_\_\_\_

Surgeries/Hospitalizations \_\_\_\_\_  
\_\_\_\_\_

Drug allergy \_\_\_\_\_ Other allergies \_\_\_\_\_  
\_\_\_\_\_

Current medications and dosage \_\_\_\_\_  
\_\_\_\_\_

Recommendations and/or restrictions \_\_\_\_\_  
\_\_\_\_\_

**If on medication for ADHD or ADD, please provide documentation from prescribing physician.**

The above is for informational use only. I understand that my personal information may be shared with the Aquinas College Student Affairs Department with the purpose of assisting me in achieving academic success and continuity of care.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**➡ PLEASE COMPLETE BOTH SIDES OF THIS FORM.**

**PART V. AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ DOB \_\_\_\_\_ Phone No. (\_\_\_\_\_) \_\_\_\_\_

E-mail address \_\_\_\_\_

I request that the Aquinas College Health Center release my Protected Medical Information (medical records) to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information to be released is as follows:

- |  |  |
|--|--|
| <input type="checkbox"/> Immunization history                  | <input type="checkbox"/> Lab reports       |
| <input type="checkbox"/> Pre-entrance physical and health form | <input type="checkbox"/> Gyn and Pap forms |
| <input type="checkbox"/> Complete progress notes               | <input type="checkbox"/> Complete records  |
| <input type="checkbox"/> Progress notes related to _____       |  |
| _____  |  |

The purpose of this release is for \_\_\_\_\_

*Example: continued care, school admission, legal, personal*

I do\_\_\_ Do not\_\_\_ N/A\_\_\_ authorize release of information related to the diagnosis and treatment of Mental Health disorders.

I do\_\_\_ Do not\_\_\_ N/A\_\_\_ authorize release of information related to the diagnosis and treatment of HIV infection, AIDS related Complex-ARC, or AIDS.

I do\_\_\_ Do not\_\_\_ N/A\_\_\_ authorize release of information related to the diagnosis and treatment of Alcohol and/or Drug Abuse.

I understand that I can change my mind and request in writing that this release no longer be honored, but that records may have been released before I notified the Aquinas College Health Center of the change. I understand that this release is valid for one year only. I release the Aquinas College Health Center from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_



**Aquinas College Health Center**  
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Grand Rapids MI 49506-1799  
**(616) 632-2969**