



GUAM COMMUNITY COLLEGE
SCHOOL OF TECHNOLOGY & STUDENT SERVICES
 Health Services Center
 Phone: (671) 735-8889/5644/5586 Fax: (671) 734-8330

EMERGENCY AND HEALTH INFORMATION

THIS INFORMATION IS CONFIDENTIAL

NAME: _____ SEMESTER/YEAR: _____
Last First Middle

GCC ID#: _____ DATE OF BIRTH: _____ SEX: () FEMALE () MALE
Banner # MM/DD/YY

MAILING ADDRESS: _____

HOME ADDRESS: _____

CONTACT NUMBERS: Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

In the event of accident or sudden illness, the information below is necessary to facilitate care and communication.

THREE (3) PEOPLE TO BE CONTACTED IN THE EVENT OF AN EMERGENCY (AND FOR A MINOR STUDENT, THOSE THAT YOU AUTHORIZE TO PICK UP YOUR CHILD):

NAME	PLACE OF WORK	HOME PHONE	WORK PHONE	CELL PHONE

MEDICAL INFORMATION:

Do you have any of the following condition/s?

- | | | | | | |
|---------------------|-----------------------------|------------------------------|--|-----------------------------|------------------------------|
| Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hearing Problem | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, do you wear a hearing aid? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Vision Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes, check the vision apparatus you are using | | |
| Epilepsy (Seizures) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Contact lenses | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Severe Allergies | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Eyeglasses | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Other health conditions not on the above list: _____

Allergies (specify to what substances) and Reactions: _____

Medications (list the names and strengths): _____

Major Surgery (include the year): _____

Serious Illness or Injury (include the year): _____

Physical or Emotional Limitations: _____

HEALTH CARE PROVIDER INFORMATION:

Name of Family Doctor: _____ Phone Number: _____ Other Number: _____

Health Insurance: _____ Name of Clinic: _____

Hospital to send you to in the event of an emergency: GMHA Naval Hospital

I, the undersigned, do hereby authorize GCC personnel to contact directly the persons named on this form, and do authorize the Health Center to render treatment as deemed necessary in an emergency. I also authorize the GCC personnel to provide the referred health agency the necessary information regarding illness or injury.

 STUDENT'S SIGNATURE (if Minor, PARENT'S SIGNATURE)

 DATE



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PARENT/GUARDIAN CONSENT FORM FOR MEDICATION ADMINISTRATION

I authorize the School Health Counselor (SHC) of GCC to administer medication in adherence to the prescribed dosage indicated in the directions by the manufacturer on the medication container. I understand that the over-the-counter medication will be administered for only those circumstances wherein my signature is affixed in the table below:

Name of Student: _____ DOB: _____ Age: _____

Name of Parent(s)/Guardian: _____ Tel. No.: _____ Cell Phone: _____

Health Problems	Over The Counter Medication to be Administered	If Allergic, Circle below	If not Allergic, Circle below	Parent Signature
Fever, Headache, Earache, Toothache, Menstrual Cramps	Acetaminophen (Tylenol)	YES	NO	
Cough or Sore Throat	Cough Drops or Lozenges	YES	NO	
Wound Care	Peroxide, Povidone Iodine, or Over-The-Counter Antibiotic Ointment	YES	NO	
Burns	Aloe Gel	YES	NO	

ALLERGIES: _____ None or No Known Allergies

_____ **Yes, please specify:** _____

Name of Parent/Guardian (Print)

Signature of Parent/Guardian

Date