GUAMCOMMUNITYCOLLEGE

SCHOOL OF TECHNOLOGY & STUDENT SERVICES
Health Services Center
Phone: (671) 735-5586/5644/8889 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 | □ No | □ Yes | Hearing Problem | □ No | □ Yes |
| High Blood Pressure | □ No | □ Yes | If yes, do you wear a hearing aid? | □ No | □ Yes |
| Diabetes | □ No | □ Yes | Vision Problems | □ No | □ Yes |
| Heart Disease | □ No | □ Yes | If yes, check the vision apparatus you are using | | |
| Epilepsy (Seizures) | □ No | □ Yes | Contact lenses | □ No | □ Yes |
| Severe Allergies | □ No | □ Yes | Eyeglasses | □ No | □ 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

*Revised ELM 6/18/15/ New Logo Update 3/8/17 ELM*

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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

*Revised ELM 6/8/15 / New Logo Update 3/8/17 ELM*