EMERGENCY & HEALTH INFORMATION FORM

THIS INFORMATION IS AND WILL REMAIN CONFIDENTIAL
In the event of accident or sudden illness, the information below is necessary to facilitate care and communication

Last Name: _____ First Name: _____

GCC ID#: _____ Semester/Year: _____

Date of Birth: _____ Sex: ☐Male ☐Female

Mailing Address: _____

Home Address: _____

Contact Numbers: Home: _____ Cell: _____ Work: _____

GCC Email: _____ Personal Email: _____

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	RELATIONSHIP	HOME	CELL	WORK/OTHER

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 ☐ GRMC ☐ 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 GCC personnel to provide the referred health agency the necessary information regarding illness or injury.

_____ _____

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

Updated: July 2026

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PARENT/GUARDIAN CONSENT FORM FOR MEDICATION ADMINISTRATION

I authorize the Health Services Center of Guam Community College 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: _____ HOME: _____ CELL: _____

Health Problems	Over The Counter Medication to be Administered	If Allergic, check below	If not Allergic, check 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**