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

FTE: ___
ADJ FAC: ___
PISA/GCM/TUTOR
DEPT: __________

FOR EMPLOYEE ONLY
HEALTH INFORMATION RECORD

THIS IS CONFIDENTIAL INFORMATION

NAME:	DATE OF BIRTH:
LAST FIRST M.I.	EMAIL ADDRESS:
MAILING ADDRESS:	(H) (W) (C)
	BANNER ID NO:
ZIP CODE:	INSURANCE: CARD NO:

In case of an ACCIDENT or SUDDEN ILLNESS, it is necessary that we have the following information to facilitate communication.

SPOUSE OR SIGNIFICANT PERSON(S) (whom you want us to contact in case of an emergency):

Name	Place of Work	Home Telephone	Work Telephone	Cell Phone

MEDICAL HISTORY:

Do you have any of the following health conditions?

Asthma □ Yes □ No
Rheumatic Fever □ Yes □ No
Diabetes □ Yes □ No
Heart Disease □ Yes □ No
High Blood Pressure □ Yes □ No
Epilepsy (Seizures) □ Yes □ No
Immune Disorder □ Yes □ No
Severe Allergies □ Yes □ No
Specify Allergies and Reactions ________________________
____
Other serious illness or injury __________________________
____
Physical or emotional limitations _______________________
____
Name of Family Doctor ______________________________
Phone Number _____________________________________
Hospital to be sent to in an emergency: □ GMH □ Naval Hospital □ GRMC

Hearing Problem (Ear) □ Yes □ No
Do you wear a hearing aid? □ Yes □ No
Vision Problem (Eye) □ Yes □ No
If yes, check the appropriate vision apparatus if used:
Wears Contact Lenses □ Yes □ No
Wears Eyeglasses □ Yes □ No
On medication (give names, strength, and doses of medications) ____
____
____
____
____
Give reason(s) for medication(s) ________________________
____
Clinic services at ___________________________________
Health Insurance ____________________________________

I, the undersigned, do hereby authorize GCC personnel to contact directly the person(s) named on this form, and do authorize the Health Center staff render such 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.

_________________________________ _______________________
SIGNATURE OF EMPLOYEE DATE

Revised ELM 9/12/16 / New Logo Update 3/7/17 ELM