DUTCHESS COMMUNITY COLLEGE
HEALTH FORM

Name of Student: _____ Birthdate: _____ Age: _____

In case of emergency, I authorize DCC personnel to act on my/our behalf in authorizing emergency medical, dental, or surgical care and hospitalization for the above named minor in the event that I/we cannot be reached.

This document will be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, or surgical care or hospitalization may be required.

PERTINENT MEDICAL INFORMATION

Child's Doctor: _____ Phone No. (_____)_____

☐ Yes ☐ No Are there allergies? If Yes, please complete Allergies form.

☐ Yes ☐ No Is medication regularly taken?* Specify drug(s) and Condition(s).

_____

***Please note that staff is not authorized to administer medications. If applicable, complete the "Medical Self-Administration" Form.**

☐ Yes ☐ No Is a special diet required? Specify diet and condition(s).

_____

☐ Yes ☐ No Are there any hearing, visual, or mobility conditions requiring special attention?

_____

☐ Yes ☐ No Are there any medical or behavioral conditions requiring special attention?

_____

_____ _____ _____

Please Print Name of Parent/Guardian Signature Date

Phones: (_____)_____ (_____)_____ (_____)_____

Cell No. Home No. Work No.

_____ (_____)_____

Alternate Local Person in Case of Emergency Phone (Please print)