

Student's Name: _____ Student's ID# _____

In the event of a medical need for the undersigned student while he/she is a student at Central Methodist University, I hereby authorize the performance upon said student such medical procedures as may be prescribed by a nurse practitioner or physician licensed to practice medicine.

Student's Signature _____ Date _____

If under 18 years of age:
Parent/Guardian Signature _____ Date _____

Parent/Guardian Address _____
Street _____ City _____ State _____ Zip _____

Parent/Guardian Ph # Home(_____) _____ Work (_____) _____ Cell Ph (_____) _____

EMERGENCY CONTACT INFORMATION

Name of Person to be Notified in Case of Accident or Other Emergency:
International students, provide name of person living in the United States that can make emergency medical decision for you.

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone Home # (_____) _____ Work # (_____) _____ Cell# (_____) _____
Email Address _____

Secondary Emergency Contact Person (optional)

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone Home # (_____) _____ Work # (_____) _____ Cell# (_____) _____
Email Address _____

Personal Physician _____ Phone # _____
Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION
New and Returning Students

Medical insurance is required for all CMU students. Parents are encouraged to review insurance issues with their student before he/she arrives on campus and to see that the student is given a copy of the insurance card to carry at all times. Should a student need care beyond the scope of the on-site health center, such as x-rays or pharmaceuticals, the student will be responsible for the bill. Every effort will be made to send the student to a facility covered under the student's health coverage plan. For this reason it would be in the student's best interest to have a list of preferred local providers if the coverage extends to the mid-Missouri area. You may wish to attach a copy of this list to this health form to be kept on file in the Student Health Center.

Is this student covered under his/her *parent's* hospital and/or sickness and accident insurance? _____ No _____ Yes

Compete the following information OR attach a photocopy, front and back, of your insurance card:

Name of Insurance Company _____
Address _____ City _____ State _____ Zip _____
Phone#(_____) _____ Name of Policy Holder _____
Group Certificate Number _____ Policy Number _____