Cabrini ID # _____

CABRINI COLLEGE
STUDENT HEALTH CENTER

CONFIDENTIAL

610 King of Prussia Road • Radnor, PA 19087
Phone (610 902-8531 • Fax: (610) 902-8282

Please make two additional copies of all forms: One for your records at home and one for participation in intramural or club sports activities.

CONTACT INFORMATION

Name: _____
Last *First* *Middle*

Soc. Sec. #: _____ **Date of Birth:** _____

College Entrance Date: (mo/yr) _____ **Class:** Fr So Jr Sr (please circle)

Gender: _____ **Resident/Commuter** _____

Home address: _____
Number and Street *City* *State* *Zip*

Home phone: _____ **Cell Phone:** _____

Student's Preferred email:_____
Parents' emails (optional) :_____

Please list up to three people whom we can contact in case of emergency: (in order of preference)

Name	*Relationship*	*Home phone*	*Work/cell phone*

FAMILY HISTORY

	Age	Occupation	Health Problems?
Mother			
Father			

Do you have any allergies to the following? Foods Latex Medications

Please specify: _____

Please list all medications or supplements you are currently taking: _____

_____

Revised 2013

Name: _____ **Soc. Sec. #:** _____

MEDICAL HISTORY

Please indicate below if you have *ever* experienced any of these problems by checking "Yes."
If you are *currently* experiencing any of these problems, please check "Currently."

EYE

Corrective Lenses/Contacts	Yes	Currently
Other Problems	Yes	Currently
Other _____		
Remarks _____		

ENT

Ear Problems	Yes	Currently
Other _____		
Remarks _____		

HEART DISEASE

High Blood Pressure	Yes	Currently
Palpitations	Yes	Currently
Heart Murmur	Yes	Currently
Other _____		
Remarks _____		

RESPIRATORY

Shortness of Breath	Yes	Currently
Asthma	Yes	Currently
Bronchitis	Yes	Currently
Other _____		
Remarks _____		

ABDOMINAL

Irritable Bowel Syndrome	Yes	Currently
Inflammatory Bowel Disease	Yes	Currently
Other _____		
Remarks _____		

ENDOCRINE

Diabetes	Yes	Currently
Thyroid	Yes	Currently
Other _____		
Remarks		

URINARY

Kidney Stones	Yes	Currently
Urinary Tract Infections	Yes	Currently
Other _____		
Remarks _____		

MUSCULOSKELETAL

Back Problems	Yes	Currently
Disease or Injury of Joints	Yes	Currently
Other _____		
Remarks _____		

HEMATOLOGICAL/ ONCOLOGICAL

Anemia	Yes	Currently
Cancer	Yes	Currently
Other _____		
Remarks _____		

NEUROLOGICAL/PSYCHOLOGICAL

Seizures	Yes	Currently
Headaches	Yes	Currently
Depression	Yes	Currently
Anxiety	Yes	Currently
Eating Disorder	Yes	Currently
Other _____		
Remarks _____		

GYNECOLOGICAL

Irregular Periods	Yes	Currently
Severe Cramps	Yes	Currently
Ovarian Cyst	Yes	Currently
Other _____		
Remarks _____		

INSURANCE WAIVER

CONFIDENTIAL

I will not be joining the insurance plan offered through Cabrini College because I have comparable coverage through another plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Cabrini College.

I will notify the Cabrini College Health Services Office if I lose my medical protection.

Full-time students wishing to enroll in the student health insurance plan need not take any action. You will automatically be enrolled and charged for the school health plan if you do not send in a waiver. You will be sent an insurance card directly from the insurance company.

I am currently covered under the following policy:

Insurance Company Name: _____ **Policy #** _____

Group # (if applicable) _____ **Policy Subscriber:** _____

Signature: _____ **Date:** _____

Though the Student Health Center does not bill insurance companies, we ***require*** that you send front and back copies of insurance and prescription cards in case of emergency.