

This form is for undergraduate students only. It does not apply to graduate, seminary or distance-learning students. Please print legibly in ink. Keep a copy for your personal records. To ensure confidentiality, this form should be mailed directly to:

Student Health Center, Grace College, 200 Seminary Drive, Winona Lake IN 46590.

PERSONAL INFORMATION

Name _____ Date of Birth _____ Gender _____
 Home Address _____ City _____ State _____ ZIP _____
 SSN or Student ID Number _____ Home Phone Number _____
 Marital Status: S M W D (Check one) E-mail address _____
 Enrolling as: Fr So Jr Sr (Check one) Semester entering Grace: Spring Summer Fall (Check one) Year: 20____
 Have you been previously enrolled at Grace? Yes No If yes, when was your last semester here? Spring Summer Fall 20____
 Name of Parent/Guardian _____ Daytime Phone Number _____
 Parent(s)' Address _____ City _____ State _____ ZIP _____
 In case of illness notify _____ Phone Number _____
 Name of Primary Care Physician _____
 Name of Clinic _____
 Address _____
 Phone Number (_____) _____ Fax (_____) _____

PERSONAL HISTORY - Have you ever had or have you now (check any items that apply to you):

- | | | | |
|---|--|---|--|
| <input type="radio"/> Acute appendicitis | <input type="radio"/> Chronic cough | <input type="radio"/> Heat cramps, heat illness | <input type="radio"/> Rheumatic fever |
| <input type="radio"/> Albumin in urine | <input type="radio"/> Colitis | <input type="radio"/> Herpes | <input type="radio"/> Scarlet fever |
| <input type="radio"/> Penicillin allergy | <input type="radio"/> Congenital defects | <input type="radio"/> High blood pressure | <input type="radio"/> Sinusitis |
| <input type="radio"/> Sulfu allergy | <input type="radio"/> Convulsions | <input type="radio"/> Histoplasmosis | <input type="radio"/> Skin disease |
| <input type="radio"/> Aspirin allergy | <input type="radio"/> Depression | <input type="radio"/> Hoarseness, chronic | <input type="radio"/> Smoke cigarettes |
| <input type="radio"/> Codeine allergy | <input type="radio"/> Diabetes | <input type="radio"/> Immune disorders | <input type="radio"/> Spitting blood |
| <input type="radio"/> Other drug allergies | <input type="radio"/> Dizziness | <input type="radio"/> Kidney disease | <input type="radio"/> Stinger, burner, pinched nerve |
| <input type="radio"/> Other food allergies | <input type="radio"/> Ear infections | <input type="radio"/> Liver disease | <input type="radio"/> Sugar in urine |
| <input type="radio"/> Inhalants (mold,dust, etc.) allergy | <input type="radio"/> Eating disorders | <input type="radio"/> Malaria | <input type="radio"/> Tendency to bleed |
| <input type="radio"/> Bee sting allergy | <input type="radio"/> Encephalitis | <input type="radio"/> Meningitis | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Other allergies | <input type="radio"/> Epilepsy/seizure disorders | <input type="radio"/> Migraine | <input type="radio"/> Trick knee, elbow, or shoulder |
| <input type="radio"/> Anemia | <input type="radio"/> Fainting spells | <input type="radio"/> Mononucleosis | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Asthma | <input type="radio"/> Frequent headache | <input type="radio"/> Organ transplant | <input type="radio"/> Tumor, growth, cyst or cancer |
| <input type="radio"/> Bloody urine | <input type="radio"/> Gallbladder disease | <input type="radio"/> Osteomyelitis | <input type="radio"/> Venereal disease |
| <input type="radio"/> Bone, joint or other deformity | <input type="radio"/> Head injury | <input type="radio"/> Pleurisy | <input type="radio"/> Viral hepatitis |
| <input type="radio"/> Chest Pain | <input type="radio"/> Heart disease | <input type="radio"/> Pneumonia | <input type="radio"/> Other _____ |
| <input type="radio"/> Chicken Pox | <input type="radio"/> Heart murmur | <input type="radio"/> Rectal trouble | |

Please comment on all "checked" answers _____

REQUIRED PHYSICAL To be completed by physician after examination

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____
 Vision: R 20 / _____ L 20 / _____ Corrected: Yes No Pupils: Equal / Unequal R > L R < L

Lungs <input type="radio"/> Normal <input type="radio"/> Abnormal	Neck <input type="radio"/> Normal <input type="radio"/> Abnormal	Back <input type="radio"/> Normal <input type="radio"/> Abnormal
Skin <input type="radio"/> Normal <input type="radio"/> Abnormal	Shoulders <input type="radio"/> Normal <input type="radio"/> Abnormal	Knees <input type="radio"/> Normal <input type="radio"/> Abnormal
Abdominal <input type="radio"/> Normal <input type="radio"/> Abnormal	Elbows <input type="radio"/> Normal <input type="radio"/> Abnormal	Ankles <input type="radio"/> Normal <input type="radio"/> Abnormal
ENT <input type="radio"/> Normal <input type="radio"/> Abnormal	Wrists <input type="radio"/> Normal <input type="radio"/> Abnormal	Feet <input type="radio"/> Normal <input type="radio"/> Abnormal
Genitals/Hernia <input type="radio"/> Normal <input type="radio"/> Abnormal	Hands <input type="radio"/> Normal <input type="radio"/> Abnormal	Other _____

Comments: _____

Please check below the activity level in which the student can participate:

- All forms of athletic and physical activity
 Restricted, supervised physical education and physical activity
 All but the most strenuous athletics and physical activity
 No forms of athletic or physical activity

Physician's Name _____ Phone _____
 Physician's Signature _____ Date _____
 (Please print)



ATHLETIC Proof of Insurance - Waiver & Release

Grace college requires proof of medical and hospitalization insurance on its student-athletes who train for, practice and participate in intercollegiate athletics.

● **Complete the form below AND attach a photocopy of the front and back of your insurance card(s).**

Athlete information: (please print)

Name: _____ Date of Birth _____ Age _____

Social Security No. _____ M F _____ Marital Status _____

Spouse's Name _____ Work Phone _____

Local/School Address _____ **Local Phone** _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Insurance Information- PRIMARY

Insurance Company _____

Name of Policy Holder _____ Relationship to Athlete: _____
(if different than athlete)

Address _____ Work Phone _____
(if different than athlete)

Policy ID# _____ Group ID# _____ Benefit Code# _____

Insurance Information-SECONDARY

Insurance Company _____

Name of Policy Holder _____ Relationship to Athlete: _____
(if different than athlete)

Address _____ Work Phone _____
(if different than athlete)

Policy ID# _____ Group ID# _____ Benefit Code# _____

Waiver & Release

By executing this form I certify that I have obtained hospital, medical and major medical insurance coverage ("Coverage"); that the Coverage is currently in effect; and that the copy of the **insurance card(s)** attached to this form is the identification card for the Coverage. I understand and agree that the Coverage is the Primary coverage (meaning that the Coverage is the first source of payment of medical expenses). I agree to indemnify (pay) Grace College for any medical expenses which I may incur and which are not paid under my Coverage. I also acknowledge that participation in intercollegiate athletics is dangerous and can result in serious injury, disability or even death.

In order to induce Grace College into allowing me to participate in College sponsored athletics and to use the facilities and equipment of the College, I, for myself and my heirs, personal representatives and assigns, hereby release and forever discharge Grace College and its officers, agents, trustees, employees, coaches and training staff of and from any and all liability, actions, causes of action, claims or demands which has or may hereafter accrue to me as a result of any injury or illness occurring to me during my participating in intercollegiate athletics and/or practice and training in connection herewith.

In time of emergency, I hereby authorize and direct Grace College to send me to the hospital or physician most readily accessible and/or to administer necessary emergency care.

Dated this _____ day of _____ 20____

Athlete's Signature _____

Effective : **2009- 2010 School year**

Parent's Signature (if athlete under 18) _____



200 Seminary Dr.
Winona Lake, IN 46590
574-372-5100, 6266

EMERGENCY INFORMATION CARD

Valid **2009-2010** School Year

Name _____ Last _____ First _____ SPORT(s) _____

Date of Birth _____ Soc. Sec. #: _____

Name of Insurance Co.: _____ Policy No. _____

Person to Notify in Case of Emergency:

Name _____ Relationship _____

Phone#: _____ Home _____ Work _____ Cell/Page: _____

List any Allergies: _____

List all Medications Taken and Reason for Taking: _____
