Georgia Gwinnett COLLEGE

Health Services

Please complete all portions of this form. The information on this form is confidential.

Name_____Student ID _____
Last first middle

Address _____
Street city state zip country

Campus Address _____Cell phone number _____

Date of Birth _____Your sex _____

Do you have medical insurance? _____Yes _____No

Name and address of medical insurance company

_____

_____ Policy number _____

Pharmacy Plan? ___Yes ____No Dental plan? ____Yes _____No

CONSENT FOR TREATMENT

I hereby consent to receive medical care (or care for my minor child or ward under 18 years of age to receive medical care) from the health care providers at GGC Student Health Services and their agents and consultants, including area hospitals. I authorize such treatment as x-rays or other diagnostic studies, as, in the judgement of the attending health care provider, may reasonably be necessary to preserve and protect my health (or the health of my minor child or ward). This consent shall remain in effect until revoked by the student (or parent) or the student is no longer enrolled at GGC.

Signature of Student _____Date _____

If the student is under 18 years of age at the time of enrollment, the form must be signed by the parent or guardian.

Signature of Parent of Guardian _____Date _____

PERSON TO NOTIFY IN AN EMERGENCY SITUATION (preferably close relative)

1. Name _____ Relationship _____
   Address _____ Office Phone _____
   _____ Home Phone _____
2. Name _____ Relationship _____
   Address _____ Office Phone_____
   _____ Home Phone_____