RHODE ISLAND COLLEGE
HEALTH SERVICES

600 MOUNT PLEASANT AVENUE
PROVIDENCE, RHODE ISLAND 02908
PHONE: 401-456-8055 FAX: 401-456-8890

PERSONAL INFORMATION

This side to be completed in full by student.

Student Name: _____
LAST NAME FIRST MI

Address: _____
STREET CITY STATE ZIP

_____ _____ _____
SOCIAL SECURITY NUMBER DATE OF BIRTH PHONE NUMBER

_____ **Sex: M** or **F** _____
STUDENT ID # CELL PHONE #

Year & Semester of Entrance to RI College: SPRING SUMMER FALL 20_____

Undergraduate Student ____ Graduate Student ____ Number of Class Credits _____

DO YOU HAVE ANY ALLERGIES? Yes or No

If yes, please list: _____

Person to be Notified in Case of Emergency: _____
NAME

Relationship: _____

Phone Number: (Home) _____ (Work) _____

Name of Health Insurance Company: _____

Mailing Address of Insurance Co.: _____

Policy #: _____ **Group #:** _____

Name of Subscriber: _____ **Subscriber's SS#:** _____

MEDICAL CARE AUTHORIZATION: I hereby grant permission to **Rhode Island College Health Services**, or its designee, to provide routine and emergency care on campus or at an off-campus medical facility including, but not limited to, laboratory, x-ray or emergency room services.

STUDENT *Signature*: _____ DATE: _____

STUDENT *Signature* is **MANDATORY**! Parental signature also required if student is less than 18 years old.

PARENT *Signature*: _____ DATE: _____

Revised
10/07