



REGIS

CENTER FOR HEALTH
AND WELLNESS

Student Health Forms

Today's Date: ____/____/____

First Name: _____ Last Name: _____ D.O.B. ____/____/____

STUDENT DEMOGRAPHIC INFORMATION, EMERGENCY CONSENT & HEALTH INSURANCE INFORMATION

STUDENT INFORMATION

Student's Name: _____ Regis ID #: _____
 First Last Middle
 Date of Birth: ____/____/____ Sex Assigned at Birth: _____ Place of Birth: _____
 month day year Country
 Permanent Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Student's Telephone Numbers: Home: (____) _____ Cell: (____) _____
 Regis Email: _____

EMERGENCY CONTACT

Name of Contact: _____ Relationship to Student: _____
 First Last Middle
 Telephone Number: _____

PRIMARY LANGUAGE SPOKEN AT HOME AND INTERPRETER NEEDS:

To support effective communication, please indicate the primary language spoken at home. If your emergency contact does not speak English, please provide the name of a person authorized to assist as an interpreter. If you (or your parent/guardian, if you are under 18) wish to list a designated individual for interpretation support, please include their information below.

Primary Language Spoken at Home: _____
 First Name of Translator: _____ Last Name of Translator: _____
 Telephone Number of Translator: _____

EMERGENCY CONSENTS

In the event of a medical or mental health emergency on campus, I authorize Regis College staff to arrange emergency transport to a medical facility if deemed necessary. I further authorize the Regis College Center for Health and Wellness to share relevant information regarding my emergency medical condition with the emergency medical personnel and necessary Regis College personnel. I authorize the Regis College Center for Health and Wellness to share my emergency contact information with Regis College personnel as needed to protect my health and safety and to ensure an appropriate emergency response. I understand that, if transported to an emergency facility, I may be required to provide clearance documentation upon my return to campus. If I am unable to provide this documentation, I understand that I will be required to obtain clearance by a Nurse Practitioner or Counselor at the Regis College Center for Health and Wellness to assess my fitness to safely return to campus activities. I understand that by typing my signature below, it serves as an electronic signature.

Student's Name: _____
 First Last Middle
 Student's Signature: _____ Date: ____/____/____
 month day year

TO BE SIGNED BY PARENT OR GUARDIAN, IF STUDENT IS UNDER THE AGE OF 18

Parent/Guardian's Name: _____
 First Last Middle
 Parent/Guardian's Signature: _____ Date: ____/____/____
 month day year

HEALTH INSURANCE INFORMATION: Please upload a front and back image of the student's insurance card.

Health Insurance Company:	Health Insurance Address:
Health Insurance Group Name:	Health Insurance Phone Number:
Member ID#	Group #:
Subscriber's Name : Subscriber's D.O.B: ____/____/____	Subscriber's Relationship to Insured: