CORBAN UNIVERSITY
Health Services Office
5000 Deer Park Dr. SE
Salem, OR 97317-9392
Phone: 503.375.7010 x2181
Fax: 503.585.4316

Comprehensive Student Health and Disability Report

STUDENT HEALTH REPORT
Early Admit Program

All information on this form will be kept confidential and will be shared with appropriate Corban personnel on a need-to-know basis only.

STUDENT INFORMATION

Name: _____ Sex: ❑ M ❑ F
Last: *First* *M.I.*

Home Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Cell: _____

Email: _____ Date of Birth: _____ Age: _____

Family Physician: _____
Name *Address* *Phone*

Parent/Guardian: _____
Name *work phone* *Home Phone*

EMERGENCY CONTACTS

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

With the understanding that every effort will be made to contact me in case of medical emergency, I hereby give my permission for the health personnel of Corban University to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for my student submitting this medical report.

Parent/Guardian Name *(please print):* _____

Signature of Parent/Guardian: _____ Date: _____

MEDICAL INFORMATION

Allergies

❑ Aspirin ❑ Insect Bites
❑ Penicillin ❑ Local Anesthetic
❑ Sulfa ❑ None
❑ Other (please explain) _____

I am currently under treatment for: _____

I take the following medications: _____

10-0199-S