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 UPDATE

Today's Date: _____

*All information on this form will be kept confidential and will be shared with appropriate Corban personnel on a need-to-know basis only. Please return your completed report to the Student Life Office as part of your registration.*

## STUDENT INFORMATION

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

Local Address: _____
*Street City State Zip*

Permanent Address: _____
*Street City State Zip*

Local Phone: _____ Cell: _____

Email: _____ Student I.D. #: _____

Age: _____ ❑ Single ❑ Married / Maiden Name: _____ Number of children: _____

Parent/Guardian/Spouse: _____ Relationship: _____

Address: _____
*Street City State Zip*

Work Phone: _____ Home Phone: _____

## EMERGENCY CONTACTS

Name: _____ Relationship: _____

Address: _____
*Street City State Zip*

Work Phone: _____ Home Phone: _____

Family Physician: _____

Address: _____ Phone: _____

## PERSONAL HEALTH HISTORY

1. Have you developed any new allergies over the past year? ❑ Yes ❑ No
   If yes, give name: _____
2. Are you currently under treatment/counseling for any physical/mental condition? ❑ Yes ❑ No
   If yes, please explain: _____
3. Are you currently taking any medication? ❑ Yes ❑ No
   If yes, please explain _____
4. Have you received any immunizations within the past year? ❑ Yes ❑ No
   If yes, please explain: _____
5. Have you been out of the U.S. in the past year?: ❑ Yes ❑ No Where? _____