EMERGENCY INFORMATION

~ PLEASE PRINT ~

Name _____ ID # _____

Last First

Date _____ Birth Date _____

Address _____

Street City State Zip

Home Phone _____

Person to contact in the event of an emergency:

Name _____ Ph/Cell Ph _____

Physician:

Name _____ Phone _____

Allergies or pertinent medical information i.e., reactions, seizures, diabetes, etc.

_____

Medications you are currently taking _____

_____

Insurance Waiver Request

We believe that our own family health insurance plan provides adequate health and accident coverage and therefore we do not wish to enroll in Bethel College's Program.

Insured by: ☐ Bethel College plan ☐ Other

If other – Insurance Company Name _____

Policy # _____ Group # _____

Policy Holder _____ Relationship to student _____

Do you wish to waive the Bethel College Student Health Insurance plan? Yes ☐ No ☐

Will you be participating in Intercollegiate Sports during the 2009-2010 School year? Yes ☐ No ☐

This waiver must be completed ENTIRELY and mailed to the Student Development Office by September 18th in order for Bethel College's Insurance charges to be removed from your student account. If faxing your form, please fax it to (574) 257-2688 and mail your original so that it reaches our office by September 18th.