

Due June 1
Confidential Medical Record
ASTA/NJ Chamber Music Institute 2008

Student's Name _____ Birthdate _____

Gender _____

Parent's Name _____ Phone _____

Address _____

Person to be notified in emergency, if other than above:

Name _____ Day and Night Phones _____

Address _____

Name and address of family doctor _____

Phone _____

1. Do you have any significant illness or disability? If so, please explain _____

2. Have you ever had any other significant illnesses, injuries, or surgeries? If so, please explain. _____

3. Are you allergic to any medication? Do you have any other allergies? If so, please explain. _____

4. What routine medications and dosages do you take? _____

Health Insurance Billing Information

Name of company _____

Claim form address _____

Policy Holder Individual ID# _____ Group# _____ Name of policy holder _____

Address of policy holder _____

**I hereby authorize Kean University Health Services to release to the
above named insurance company, information from my medical
record as needed in presenting my claim for benefits.**

Student's signature _____ Date _____

Parent's signature _____ Date _____

I hereby give my consent for the treatment of _____

first middle last Date of Birth

**This authorization covers any procedure which may be deemed
advisable by the attending staff physician and/or consultant.**

Signature of person (other than parent) authorized to give consent for patient treatment:

Name _____ Relationship _____

Witness _____ Date _____