WINTHROP UNIVERSITY

Center for Student Wellness
Division of Student Affairs

Name: Account No:
Date: DOB:

STUDENT INFORMATION
Enrollment date:
Cell #:
E-mail:
Local address (including city and state):
Permanent address (including city and state):
Sex:
Race/Ethnicity:
Allergies: (please explain):
Current medications: (please explain):
Current medical condition: (please explain):
Significant medical history: (please explain):

EMERGENCY CONTACT INFORMATION
Emergency contact:
Relation to student:
Contact #:
Alternative #:
Work #:
Address (including city and state):

CONSENT FOR CARE
By electronically signing below, you are hereby authorizing the medical staff of Winthrop University Health Services to provide medical treatment and/or procedures as necessary. You understand that there is no charge for an office visit, but that you may incur charges for lab tests, supplies or medicines that will be billed to your student account. Winthrop University Health Services does not accept or file health insurance claims but will provide the documentation necessary for you to file. You further authorize release of information to my insurance carrier if requested.

Student Signature: Date:

WU ID#:

Parent Signature:
If student under 16, in accordance with SC Law Code Section 63-5-340 Date:

Legal Guardianship Signature: Date:

Health Services • Counseling Services • Health Promotion • Student Advocacy & Trauma Support

803/323-2206
803/323-3332 (fax)
wuhealth@winthrop.edu
www.winthrop.edu/csw
Rock Hill, SC 29733