

KU STRINGWORKS HEALTH FORM

Health Services

The Student Health Service of the University of Kansas at Watkins Health Center provides health services for students enrolled in the Stringworks Workshop. The scope of medical care is identical to that provided for regular students of the University. Our staff consists of full-time physicians and other professional personnel. Services of the Health Center are of high quality and provide care for most health needs of students. Watkins Health Center is open from 8:00 a.m. until 8:00 p.m., Monday through Friday, and 8:00 a.m. until 4:30 p.m. on Saturday, and 12:30 p.m. until 4:30 p.m. Sunday. Of course emergency care at any time is available at the Emergency Room of Lawrence Memorial Hospital.

Costs for these services are charged to the patient, parent, or their insurance.

Our experience has shown that it is highly desirable that we have a background health record on each student and we appreciate you furnishing the information requested on the reverse side of this sheet so that the Stringworks staff can bring it in with student if the need arises.

A witness that is at least 18 years of age must sign the form.

Please do not hesitate to contact us at any time if you have any questions, or if we can be of service to you. We join everyone at the University of Kansas in extending our warmest best wishes to you for a happy and rewarding session at KU Stringworks.

Watkins Health Center
Student Health Services
The University of Kansas
Lawrence KS 66045-8830
(785) 864-9500

**PLEASE MAIL IN THIS FORM IN THE SAME ENVELOPE WITH YOUR
APPLICATION AND FEE**

[HTTP://STRINGWORKS.KU.EDU](http://stringworks.ku.edu)

338 MURPHY HALL, 1530 NAISMITH DR. • LAWRENCE, KANSAS 66045-3102 • (785) 864-9718 • FAX: (785) 864-5866

KU Stringworks Medical Form
CONFIDENTIAL MEDICAL RECORD
(Please mail in with your application)

Student's Name: _____ Sex: ___ Birthdate: ___/___/___
Student's Social Security #: _____
Parent's Name _____ Parent's Social Security #: _____
Phone: () _____-_____
Address: _____ City: _____ State: _____ Zip: _____

PERSON TO BE NOTIFIED IN EMERGENCY, IF OTHER THAN ABOVE:

Name _____
Phone: () _____-_____
Address: _____ City: _____ State: _____ Zip: _____

NAME AND ADDRESS OF FAMILY DOCTOR

Doctor's Name _____ Phone: () _____-_____
Address: _____ City: _____ State: _____ Zip: _____

1. Do you have any significant illness or disability? _____ If so, please explain _____
2. Please check if you have or have had any of the following:

_____ Measles	_____ Diphtheria	_____ Polio	_____ Epilepsy
_____ Mumps	_____ Rheumatic Fever	_____ Tuberculosis	_____ Diabetes
_____ Chicken Pox	_____ Kidney Trouble	_____ Asthma	_____ Fainting
3. Have you had any other significant illnesses, injuries, or surgeries? YES NO
If so, please explain: _____
4. Please give date of most recent immunization:
Tetanus _____ Smallpox _____ Diphtheria _____
Typhoid _____ Polio (oral) _____ Other _____
5. Are you allergic to any medication? YES NO Any other allergies? YES NO
If so, please explain: _____
6. What routine medications & dosages does the student take? _____

HEALTH INSURANCE BILLING INFORMATION

Name of company: _____ Claim Form Address: _____

Policy Holder Individual ID # _____ Group # _____ Name of policyholder: _____
Address of policyholder: _____ City: _____ State: _____ Zip: _____

I hereby authorize Watkins Memorial Health Center 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 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 authorized to give consent for patient treatment:
Name _____ Relationship: _____

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Witness _____ Date: _____