Medications, Medical History, and Emergency Contact Information

Name (please print):_____

Allergies: No___ Yes___ To What: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____ Mobile Phone: _____ Work Phone: _____

Primary Physician: _____ Phone: _____

Physician Fax: _____ Physician Address: _____

Current Medications: Please list any medication that you are currently taking. Include non-prescription medications, vitamins, or supplements. If you need more space, please include an additional page.

Name of Medication	Dosage	Months/Years on Medication

Past Medical History: Do you now have or have you ever had: (please check all that apply)

___Diabetes
___High Blood Pressure
___High Cholesterol
___Hypothyroidism
___Goiter
___Cancer (type_____)
___Leukemia
___Psoriasis
___Angina
___Heart Problems
___Head Injury
___ Diagnosis of COVID-19
___ COVID -19 Vaccine
___Heart Murmur
___Pneumonia
___Pulmonary Embolism
___Asthma
___Emphysema
___Stroke
___Epilepsy/Seizures
___Cataracts
___Kidney Disease
___Kidney Stones
___Bleeding Disorder
___Crohn's Disease
___Colitis
___Anemia
___Jaundice
___Hepatitis
___Stomach or Peptic Ulcer
___Rheumatic Fever
___Tuberculosis
___HIV/AIDS
___Sickle Cell Disease
___Other (Please Explain)

Please return this completed form to one of the following:

Email - healthservices@sunysullivan.edu
Fax - (845) 434-3628
Mail to:

SUNY Sullivan - Health Services
112 College Road
Loch Sheldrake, NY 12759