

College ID# _____
Student Cell Phone # (required) _____

**RETURN THIS FORM TO:
UNIVERSITY OF RHODE ISLAND
DR. PAULINE B. WOOD HEALTH SERVICES
MEDICAL RECORDS
6 BUTTERFIELD ROAD
KINGSTON, RI 02881
FAX: (401) 874-5772 OR (401) 874-9110**

**UNIVERSITY OF RHODE ISLAND • DR. PAULINE B. WOOD HEALTH SERVICES
STUDENT CONTACT INFORMATION SHEET**

NAME _____ DATE OF BIRTH _____
LAST FIRST M.I.

HOME ADDRESS _____
STREET CITY, STATE ZIP CODE

CELL PHONE (*REQUIRED) _____ HOME PHONE NUMBER _____

STATUS: FULL TIME PART TIME UNDERGRAD GRAD

AGE _____ PLACE OF BIRTH _____ RACE _____

SEX: FEMALE MALE

SPECIFY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY: _____
NAME

STREET CITY, STATE ZIP CODE

PHONE # (INCLUDING AREA CODE) CELL PHONE # (INCLUDING AREA CODE)

NAME OF FAMILY PHYSICIAN: _____

STREET CITY, STATE ZIP CODE PHONE # (INCLUDING AREA CODE)

******* PARENTS OF STUDENTS UNDER 18 PLEASE COMPLETE THIS SECTION *******

I hereby grant permission to University of Rhode Island Health Services to provide any medical treatment for my son/daughter _____ deemed necessary by the Health Services staff.
STUDENT'S NAME

I understand that every effort will be made to notify me in the event of major illness or injury.

SIGNATURE DATE

RELATIONSHIP

STUDENTS 18 YEARS OF AGE OR OLDER

You, as an adult, have control over your health care and information regarding your health. You make decisions regarding your care and only you may authorize the release of information contained in your medical record (exceptions are emergencies or as required by law). We at Health Services are very sensitive to the confidentiality of health care information. You may authorize the release of your health record and Health Services has a specific form that you would complete and sign.