

Student Name: _____

Family History

	Age	State of health	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Have any of your relatives ever had any of the following?:

	Yes	Relationship
Tuberculosis	_____	_____
Diabetes	_____	_____
Hypertension	_____	_____
Heart disease	_____	_____
Arthritis	_____	_____
Hay fever	_____	_____
Cancer	_____	_____

ATTESTATION

Medical information withheld, incomplete or incorrect relieves Wabash College and its agents from all medical or legal liability and may disqualify you from participation in athletics or club sports. The information given on this form is correct to the best of my knowledge. I give permission for this information to be shared, when necessary for my treatment, payment for services or for health care operations of the Wabash College Student Health Center and the Wabash College Athletic Department.

Signature if student over 18

Date

Parent/guardian signature if under 18

Relationship

Date

Record any additional details/information below: