MESSIAH COLLEGE

Office of Disability Services

MEDICAL RESPONSE PLAN

Effective Date: _____ **Review/Termination Date: _____**

Applicant Name: _____ Student ID#: _____
Last First MI

Residence Building: _____ Room _____ Telephone: _____

Home Address: _____Home Phone: _____

INSTRUCTIONS SPECIFIC TO MY MEDICAL CONDITION:

1. Type of Medical Disorder _____

2. Medications taken:_____

3. Medication location: _____

4. Symptoms/Manifestations:

Mild/Moderate:	Severe/Emergency Level:
Response:	□ Call Paramedics □ Transport to emergency room □ Other _____

5. Preferred local hospital if needed: _____

6. Friend to call_____
Name Phone

7. Family to notify_____
Name Phone

I give my permission to release the information provided above to Messiah College Department of Safety, Residence Life, Engle Center, and faculty in whose classes I am registered. I understand that emergency medical assistance may be summoned by Messiah College personnel and agree to be fully responsible for the cost of such assistance. **I am aware that I may refuse emergency medical assistance after it has arrived.** I release Messiah College, its employees, officer and trustees, from all liability for injury or loss which I may suffer as a result of my health condition.

Signature of Applicant _____ Date _____

Signature of Parent (if applicant is under 18) _____

Distribution:

Applicant		Dept of Safety		Disability Services		Residence Director	
Engle Center		Residence Life		Emergency Dispatch			