Please return all completed forms to The Wellness Center, Room S213 Tower Hall or return in enclosed envelope.

UNIVERSITY OF ST FRANCIS

STUDENT PROFILE

Please check all that apply:

____College of Nursing/Allied Health **_____Resident** **_____ Commuter**

Name _____ ID# _____

Last First M.I. (Maiden)

Date of Birth _____

Place of Birth: State/Country _____

Student Address _____ Home Telephone _____

_____ Work Telephone _____

Parent/Spouse Name _____ Relationship _____

Address _____

(Street) (City) (State) (Zip)

Employer _____ Title _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

Telephone _____ Telephone _____

Physician Name _____ Physician Telephone _____

Physician Address _____

_____

Health Insurance Carrier _____

Policy Holder's Name (parent, spouse) _____

Policy # _____ Group # _____

Is the plan listed above a Health Maintenance Organization (HMO)? _____Yes _____ No

Does your insurance plan require prior approval before treatment? _____Yes _____No

Does your insurance plan require you to go to a specific physician/hospital? _____Yes _____No

If yes, specify _____

Do you need any special assistance from the University of St. Francis? If so, please describe

_____

Note: A Student Directory is published each semester including your name, address, and phone number. If you do not wish your address or phone number released, please notify the Student Life Office.

500 WILCOX STREET JOLIET, ILLINOIS 60435 (815)740-3848 FAX (815) 740-5035
www.stfrancis.edu/healthservice.htm