

# THE MEDICAL CENTRE REGISTRATON 2009/2010

## Personal Details

Student Number: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Waterford Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Medical Details

Do you have any of the following Medical Conditions?

Asthma [ ] Diabetes [ ] Physical Disabilities [ ]

Epilepsy [ ] Other [ ]

Past illness or operations: \_\_\_\_\_

Any Relevant Family History: \_\_\_\_\_

Current Medication: \_\_\_\_\_

Allergies: \_\_\_\_\_

## Payment Details

Please indicate if you wish to avail of a Scheme Yes [ ] No [ ]

Annual Fee €100.00

Method of Payment: Cash /Cheque [ ]

Laser Card/Credit Card [ ]

WIT Smart Card [ ]

or

Medical Card (no payment required) [ ]

Please indicate your year of study 1<sup>st</sup> [ ] 2<sup>nd</sup> [ ] 3<sup>rd</sup> [ ] 4<sup>th</sup> [ ]

Please make cheques payable to "THE MEDICAL CENTRE".

If you wish to pay by Credit Card: Card Holders Name: \_\_\_\_\_

Card Number: \_\_\_\_\_

(last 3 digits beside signature on card) Security Number: \_\_\_\_\_

Expiry Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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**COMPLETED FORMS SHOULD BE RETURNED**

**(with appropriate fee where applicable)**

**TO: THE MEDICAL CENTRE, 29. BARRONSTRAND STREET, WATERFORD**

**OR**

**THE MEDICAL CENTRE, WATERFORD INSTITUTE OF TECHNOLOGY,  
WATERFORD**