

MEDAILLE COLLEGE MEDICAL HISTORY FORM

(To be completed by student)

Please print:

NAME _____
Last First MI

DOB _____ **SS** _____ **PHONE** _____ **SEX** F M

ADDRESS _____
Street City State Zip

EMERGENCY CONTACT _____ **HOME PHONE** _____
Name Relationship

ADDRESS _____ **BUSINESS PHONE** _____

PRIMARY PHYSICIAN _____ **PHONE** _____

ADDRESS _____
Street City State Zip

Please (X) all the medical problems you have or have had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Recurrent Nosebleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Frequent Ear, Nose, Throat Infections | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Collagen Disease | <input type="checkbox"/> Joint/Back Trouble | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Drug Abuse/Dependency | <input type="checkbox"/> Neurological Disorders | |

Please explain all checks: (Use the rear of form if necessary)

Do you smoke? **YES/NO** _____ Packs/Day Do you use alcohol? **YES/NO** _____ /Week

FEMALES:

Irregular Periods _____ Severe Cramps _____ Excessive Flow _____

Are you allergic to any medication? Please list: _____

Are you allergic to any food/insect/environmental allergen? Please list: _____

Any surgeries or serious injuries? Please list: _____

Are you on any medications? Please list: _____

AUTHORIZATION OF HEALTH SERVICES FOR STUDENTS UNDER 18 YEARS OF AGE

I am the parent or legal guardian of the above mentioned student, and I understand that situations may arise in which the student may need to be treated in the Student Health Center for a medical condition while at school and it may not be possible for the College to notify me before the care is rendered. I further understand that the College will make its best effort to notify me of this situation; however, if such notice is not possible, I authorize that care be rendered. Also, in the event of an emergency, I hereby authorize the Student Health Center to refer the student to a physician, health care institution, or other healthcare provider to perform any diagnostic, medical, or surgical treatment deemed necessary by the College Health Center.

Signature of Parent/Guardian

Date