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:

☐ Alcoholism	☐ Eating Disorder	☐ Polio
☐ Anemia	☐ Emphysema	☐ Rashes
☐ Arthritis	☐ Emotional Problems	☐ Recurrent Nosebleeds
☐ Asthma	☐ Fainting/Dizziness	☐ Rheumatic Fever
☐ Bleeding Disorder	☐ Frequent Ear, Nose, Throat Infections	☐ Seizure Disorder
☐ Blood Pressure Problems	☐ Gall Bladder Problems	☐ Sexually Transmitted Diseases
☐ Bronchitis	☐ Hearing Loss	☐ Sinusitis
☐ Cancer	☐ Heart Disorder	☐ Stomach Disorders
☐ Cerebral Palsy	☐ Hypoglycemia	☐ Stroke
☐ Collagen Disease	☐ Joint/Back Trouble	☐ Thyroid Disease
☐ Colitis	☐ Kidney/Bladder Problems	☐ Tuberculosiss
☐ Depression	☐ Migraine Headaches	☐ Vision Problems
☐ Diabetes	☐ Musculoskeletal Disorders	☐ Other
☐ Drug Abuse/Dependency	☐ 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 injures? 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**