REQUIRED STUDENT HEALTH HISTORY

CONFIDENTIAL

Part I: To be completed by student

Name: ____
LAST FIRST MI

Permanent Address: ____
NUMBER AND STREET CITY STATE ZIP CODE

Home Phone: ______________________ **Birth Date:** ____________________

Person To Notify In Case Of Emergency:

____
NAME RELATIONSHIP DAY PHONE NIGHT PHONE

**All students must be covered by Hospitalization Insurance.

Are you presently covered? ☐Yes ☐No

________________________________ ________________________________
COMPANY NAME POLICY NUMBER

Part II: To be completed by physician

Sex: ☐Female ☐Male **Age:** ________ **Height:** _________ feet _______ inches **Weight:** ______pounds

Please attach physician's statement regarding exemptions or exceptions where applicable.
Please elaborate all Yes answers on separate sheet, giving dates where applicable.
Do you now have or have you had:

DIABETES	☐Yes ☐No
SEIZURES OR FAINTING SPELLS	☐Yes ☐No
WEIGHT OR EATING PROBLEMS	☐Yes ☐No
RESPIRATORY PROBLEMS	☐Yes ☐No
BACK OR JOINT PROBLEMS	☐Yes ☐No
ALLERGIES (general, medications, foods)	☐Yes ☐No
FREQUENT OR SEVERE HEADACHES	☐Yes ☐No
MENSTRUAL PROBLEMS	☐Yes ☐No
INDIGESTION, DIARRHEA OR FOOD INTOLERANCE	☐Yes ☐No
MALARIA	☐Yes ☐No
PSYCHIATRIC CARE	☐Yes ☐No
MAJOR MEDICAL OR SURGICAL HISTORY	☐Yes ☐No

What immunizations have you had? **Date**

MEASLES, MUMPS, RUBELLA	☐Yes ☐No	_________
TETANUS/DIPHTHERIA (within 5 years)	☐Yes ☐No	_________
POLIO	☐Yes ☐No	_________
TUBERCULIN SKIN TEST	☐Yes ☐No	_________
HEPATITIS B	☐Yes ☐No	_________
MENINGITIS	☐Yes ☐No	_________

Please list prescribed medications you are taking ______________________________

____

Please list over-the-counter medications you are taking ______________________________

____

To the best of my knowledge all answers are correct.

______________________________ ______________
PHYSICIAN'S SIGNATURE DATE

____
NUMBER AND STREET CITY STATE ZIP CODE