

MEDICAL HISTORY FORM

All medical information is **CONFIDENTIAL**.
 The information provided is strictly for the use of Health Services
 and will not be released to anyone without your written consent.

(Print) LAST NAME _____ FIRST NAME _____ MIDDLE _____ SSN _____

HOME ADDRESS (STREET & NUMBER) _____ CITY _____ STATE _____ ZIP _____

HOME PHONE NUMBER _____ STUDENT CELL PHONE NUMBER _____

Gender MALE FEMALE _____ Is the student 18 years of age or older? YES NO
 DATE OF BIRTH _____

If NO, please sign as follows: "I hereby give my permission for Alvernia University's Health Services medical staff to provide medical services to the above-named student as needed."

SIGNATURE OF PARENT OR GUARDIAN

EMERGENCY CONTACT: NAME _____ DAY TIME PHONE _____ CELL PHONE _____ RELATIONSHIP _____

INSURANCE ** THIS INFORMATION IS NECESSARY FOR ANY LAB TESTS THAT MAY BE SENT OUT OR IN CASE OF AN EMERGENCY**
 ALL STUDENTS MUST HAVE HEALTH INSURANCE

POLICY INFORMATION

Insurance Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

ID#: _____ Group #: _____

If HMO, list name of Primary Care Physician: _____

Phone #: _____ Fax #: _____

CARRIER INFORMATION

Name of person carrying insurance: _____

Address: _____

Phone #: _____ SSN: _____

Employer: _____

Address: _____

Phone #: _____

ALLERGIES

Are you allergic to any medication(s) or latex? YES NO

If yes, list medication(s) and reaction(s): _____

Do you have any food/environmental allergies? YES NO

If yes, please list: _____

MEDICATIONS

Are you currently taking daily medications? YES NO

If yes, please list (include prescription drugs, vitamins, contraceptives, over-the-counter medications taken regularly, etc.)

FAMILY HISTORY

Relation	Age	General Health	Past/Present Serious Illness	If deceased, age and cause of death
Father				
Mother				
Sibling				

(Print) LAST NAME FIRST NAME MIDDLE SSN

PERSONAL HISTORY

	YES	NO		YES	NO		YES	NO
Chicken Pox			Asthma			Concussion		
Measles			Chronic Cough			Dizziness/Fainting		
Mononucleosis			Shortness of Breath			Headache (recurrent)		
Mumps			High Blood Pressure			Skin Condition		
Rheumatic Fever			Heart Disease			FEMALES ONLY		
Tuberculosis			Heart Murmur			Excessive Flow		
Diabetes			ADD/ADHD			Irregular Periods		
Kidney Disease			Alcohol/Drug Dependency			Severe Cramps		
Gallbladder Problems			Anxiety			MALES ONLY		
Diarrhea (recurrent)			Depression			Testicle Problems		
Back Problems			Eating Disorder			Hernia		

Do you have an illness or condition not listed above, for which you are now being treated? If yes, please specify: _____

Have you ever had any significant injuries, e.g. head injury, fractures, or any other trauma? If yes, please specify type of injury and date of occurrence.

Please list types and dates of any hospitalizations and/or surgeries.

SOCIAL HISTORY

Do you smoke? YES NO
If yes, how often (packs per day)? _____

Do you use recreation drugs? YES NO
If yes, type and frequency? _____

Do you chew smokeless tobacco? YES NO
If yes, how often? _____

Do you drink alcohol? YES NO
If yes, average number of drinks at one time? _____
Number of times/week? _____

THIS MUST BE SIGNED BY THE STUDENT: I certify that the information entered is complete and accurate.

Student Signature

Date

IMMUNIZATION RECORD

The following immunizations are **REQUIRED** by Alvernia University. This record must be completed and signed by your health care provider OR a copy of your state immunization records from your high school nurse is acceptable. (Please specify month and year for all immunizations.)

DPT (Diphtheria/Pertussis/Tetanus)	1	2	3	4	5
TD (Tetanus/Diphtheria) within 10 years of attendance/every 10 years as an adult				1	2
MMR (Measles/Mumps/Rubella) 2 IMMUNIZATIONS REQUIRED or Blood Titer (copy of lab report must be attached)				1	2
Polio (oral or trivalent)		1	2	3	4
Hepatitis B			1	2	3
Varicella (Chicken Pox) Vaccination or date of disease				1	2
Meningococcal Vaccination REQUIRED BY PA LAW FOR STUDENTS LIVING IN RESIDENCE HALLS **You may opt to decline the Meningococcal Vaccination. In order to do so, you must read the enclosed Meningococcal Vaccination Information Sheet and sign the waiver statement below.				Menommune OR Menactra	1

Signature of Health Care Provider

Printed Name of Health Care Provider

Date

Phone Number

MENINGITIS WAIVER

I, _____, have read the Meningitis Vaccination Information Sheet and understand that in declining this vaccine I continue to be at risk for this serious and sometimes fatal disease. I hereby decline the meningitis vaccine at this time.

Student Signature

Date

Witness Signature

Date

