STUDENT HEALTH SERVICES

Health Questionnaire

Name____Date of Birth ________________________
last first middle initial

Address ____
street city state zip

Sex_____________SS#_____________________Anticipated term of entry GC&SU _______________

Name of Medical Insurance Company ____

Policy Number____

Name of Insured ___________________________________Insured's SS# _______________________

Address of Insurance Co. ____

Please complete all portions of this form

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES
I hereby authorize the health care providers at Student Health Services and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures, which in their judgment may become necessary while at Georgia College & State University.

Student Signature _______________________________**Date** _____________________________

Parent Signature ________________________________**Date** _____________________________
(If student is under 18 years of age at time of enrollment) With this signature I waive all claim to prior notification. I understand that if, in the judgment of the professional staff, the student's parent or guardian should be notified, this will be done.

Person to Notify in an Emergency Situation (preferably close relative)

1. Name ____Relationship ________________________

   Address_______________________________________Office Phone________________________

   ____Home Phone________________________

2. Name ____Relationship ________________________

   Address_______________________________________Office Phone________________________

   ____Home Phone________________________

over

Medical History

1. Do you have or have you had any of the following?

Condition	Yes	No
Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Are you allergic to		
Chicken/Eggs	☐ Yes	☐ No
Other foods	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Other Drugs	☐ Yes	☐ No
Bleeding/Hemophilia	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No
Ear Infection	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Learning Disability	☐ Yes	☐ No
Measles	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No
Mumps	☐ Yes	☐ No
Nervous/ Emotional Problems	☐ Yes	☐ No
Periods of Unconsciousness	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Surgical Operations	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Visual or Hearing Impairment	☐ Yes	☐ No
Any Physical Disability	☐ Yes	☐ No

(Describe) ______________________________

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2. If you have answered YES to any of the above, please describe below and have your physician forward a summary of your treatment of any current condition to Student Health Services, Campus Box 91, GC&SU, Milledgeville, GA 31061.

3. Please list any disabilities because of which the University may need to provide you with special assistance __________

4. Have you ever consulted a psychiatrist or psychologist?_________ Are you now under treatment?_________
Nature of illness______________________________
Name and address of doctor consulted______________________________

____

5. Do you take any prescribed medication on a regular basis? Yes No. If yes, please list medications by name: ______

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6. Tetanus Status: Tetanus Booster Date______________________(Should have received in past ten years)

7. Tuberulin Skin Test (Should be administered within 6 months of arrival on campus) Date______________________
Negative Positive

8. Chest x-ray (required if skin test is positive) Date ______________________Negative Positive
If positive, give details of treatment ______________________________

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The information on this form is confidential and will be used only in matters concerning your health. Mail completed form to:

Student Health Services
Georgia College & State University
Campus Box 91
Milledgeville, GA 31061-0490

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