

ANDREW COLLEGE HEALTH INFORMATION SHEET

Full Name _____ Date _____
PRINT LAST FIRST MIDDLE INITIAL

Home Address _____
STREET CITY STATE ZIP

Date of Birth _____ Age _____ Sex _____ Race _____

Name of Parents or Guardian _____

Telephone # (Home) _____ (Work) _____ (Cell) _____

Name & Address of Family Physician _____

When was your last physical examination? _____

Purpose of Examination _____ *Routine Check Up* _____ *Illness/Injury*

Notes _____

1. Do you have a health problem? (Check where appropriate)
_____ *Asthma* _____ *Diabetes* _____ *Vision* _____ *Blood Disorder/Anemia* _____ *Injury* _____ *Hepatitis*
_____ *Allergies* _____ *Hernia* _____ *Hearing* _____ *Seizures/Convulsions* _____ *Heart* _____ *Headaches*
_____ *Bone/Joint* _____ *Urinary* _____ *Skin* _____ *Psychological* _____ *Kidney* _____ *Digestive*
_____ *Other*

2. Do you take medication? _____ Yes _____ No

3. Are you currently under the care of a medical professional? _____ Yes _____ No

4. If the answer to # 3 is yes, name and contact information of medical professional. _____

5. Prescriptions: _____
Over the Counter Drugs _____
_____ I am not currently taking any medications.

6. List any injuries/surgeries _____ N/A
Injury/Surgery _____ *Date(s)* _____
_____ _____
_____ _____

7. List any allergic reactions to medications or injections: _____ N/A _____

8. Is there additional information about your health that you think is important for us to know?
Explain: _____

9. Do you know of any reason why you could not participate in an unlimited athletic program? _____ YES _____ NO

10. If answer to #9 is yes, please explain: _____ N/A

11. It is strongly recommended that all students have medical insurance either through their parents' policy or individually. Many physicians and hospitals now require either evidence of insurance or pre-payment as a condition for treatment.

INSURANCE CO. _____ POLICY NUMBER _____

To the best of my knowledge the above information is true and correct: _____
SIGNATURE DATE

Permission for Treatment In the event of serious illness or injury, or the need for major surgery, I understand an attempt will be made by a physician or Andrew College to contact the parent, guardian, or designated contact. If said physician or College is unable to communicate with any of the above listed individuals, the necessary treatment for the above student may be given. A parent or guardian must sign if the student is under 18 in order for medical treatment to be given. If statement is not signed, the hospital/doctor must first get permission from the parent/guardian before medical treatment is administered.

PARENT/GUARDIAN _____ DATE _____

STUDENT _____ DATE _____

Athletics If I chose to participate in Andrew College Athletics, I understand that a copy of the Health Information Form will be forwarded to the Athletic Trainer.

STUDENT _____ DATE _____

**Statement Regarding Meningococcal Disease
(Meningitis) Immunization**

In compliance with House Bill 52 of the Georgia General Assembly the following information, to take effect on January 1, 2004, is required for you to know:

- (1) Meningococcal disease is a serious disease that can lead to death within only a few hours of onset; one in ten cases is fatal; and one in seven survivors of the disease is left with a severe disability, such as the loss of a limb, mental retardation, paralysis, deafness, or seizures;
- (2) Meningococcal disease is contagious but a largely preventable infection of the spinal cord fluid and the fluid that surrounds the brain;
- (3) Scientific evidence suggests that college students living in dormitory facilities are at a moderately increased risk of contracting meningococcal disease; and
- (4) Immunization against meningococcal disease will decrease the risk of the disease.

Andrew College strongly recommends that all persons staying in a resident hall be immunized against meningococcal disease (meningitis).

I, _____, with signing this document, have read and understand the above statements regarding meningococcal disease (meningitis).

_____ Check here only **if you know you have been immunized** against meningococcal disease (meningitis).

Signature of Student _____
Date

Signature of Student's Legal Guardian if less than 18 years of age _____
Date

Please Print Information and Return to Student Life