Andrew College
1854

ANDREW COLLEGE HEALTH INFORMATION FORM

Full Name_____Date_____
PRINT LAST FIRST MIDDLE INITIAL

Home Address_____
STREET CITY STATE ZIP

Student Cell Phone Number_____Student Email_____

Date of Birth_____Age_____Sex_____Race_____

Name of Parent(s) or Guardian_____

Phone Numbers (Cell) _____ (Work) _____ (Home) _____

Name & Address of Family Physician_____

When was your last physical examination? _____

Purpose of Examination_____*Routine Check Up* _____*Athletic Team Check Up* _____*Illness/Injury*

Notes_____

1. Do you have a health problem(s)? (Check where appropriate)

HEALTH ISSUE (Check All Applicable)	Do you take Medication to Control it?	HEALTH ISSUE (Check All Applicable)	Do you take Medication to Control it?
Asthma	**Yes or No**	Skin/Dermatological	**Yes or No**
Diabetes	**Yes or No**	Kidney	**Yes or No**
Blood Disorder/Anemia	**Yes or No**	Digestive	**Yes or No**
Hepatitis	**Yes or No**	Headaches/Migraines	**Yes or No**
Hernia	**Yes or No**	Vision	**Yes or No**
Seizures/Convulsions	**Yes or No**	Hearing	**Yes or No**
Heart Issues	**Yes or No**	Allergies (Severe)	**Yes or No**
Bone/Joint	**Yes or No**	Psychological	**Yes or No**
Urinary	**Yes or No**	Recent Injury\Surgery	**Yes or No**

Other _____

_____

2. Do you take any medication(s)? _____Yes _____No

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3. Are you currently under the care of a medical professional? _____Yes _____No

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

_____

_____

5. I am not currently taking any medications. _____Yes _____No

List Prescriptions
Medications:_____

_____

List Over-the-Counter
Medication/Drugs:_____

_____

6. Any injuries/surgeries _____Yes _____No. If **Yes**, list any Injuries/Surgeries"

Injury/Surgery	*Date(s)*
_____	_____
_____	_____
_____	_____

7. Allergic reactions to medications or injections: _____N/A

List any Allergic Reactions to Medications or Injections:_____

_____

8. Is there additional information or details 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:_____

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:_____

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I, _____ (PRINT NAME), attest that to the best of my knowledge the information provided within this form is true and correct.

_____
SIGNATURE 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, _____(PRINT NAME), 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). Date of Immunization: _____

_____
Signature of Student Date

Printed Name
PARENT/GUARDIAN_____

_____
Signature of Student's Parent or Legal Guardian (if less than 18 years of age) Date

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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.

Printed Name
PARENT/GUARDIAN_____DATE_____

PARENT/GUARDIAN Signature_____

Printed Name
STUDENT _____DATE_____

STUDENT Signature_____

Athletics/Athletes

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.

Printed Name
STUDENT _____DATE_____

STUDENT Signature_____

REQUIRED FOR HOUSING ASSIGNMENT
Please Print and Return to Office of Student Affairs

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