

Student Health History

Morehead State University
(606) 783-2055

Caudill Health Clinic
Allie Young Hall
Morehead, KY 40351

To the student: Completion of this report is required before treatment at the Caudill Health Clinic at Morehead State University. All health information is confidential and will be placed on file in the Caudill Health Clinic. Please read carefully and answer all questions on both sides of the form. Consult you parents/guardian for complete and accurate information. You may need to consult your family physician or public health department for an accurate immunization record. The completed form should be returned to the Caudill Health Clinic at the address above.

Student Information (please print)

Name _____
last first middle

Social Security Number _____ Date of Birth ____/____/____ Age ____ Male Female
month day year

Home Address _____ Phone _____
number and street city state zip area code

When do you plan to enroll in Morehead State University? fall ____ spring ____ summer ____
year year year

Medical History Check *yes* or *no* for each item listed and indicate *year* for each *yes* response. If any medical condition still exists for which a *yes* response was given, please give additional information on an attached sheet.

YES	NO		YEAR
		measles	
		mumps	
		chicken pox	
		mononucleosis	
		anemia or blood disease	
		heart murmur/heart disease	
		rheumatic fever	
		high blood pressure	
		clots in veins	
		gynecological problems	
		asthma	
		pneumonia	
		orthopedic injuries, fractures, surgeries	
		cancer	

YES	NO		YEAR
		tuberculosis	
		mental health care	
		meningitis	
		convulsions or seizures	
		paralysis	
		severe headaches	
		head injury with unconsciousness	
		stomach or intestinal trouble	
		ulcer	
		hepatitis (yellow jaundice)	
		gallbladder disease	
		thyroid disease	
		diabetes	
		bladder/kidney disease	

Have you had any illness, injuries, or hospitalization not already noted? yes no. If yes, explain on an attached sheet.

Have you ever had surgery? yes no. If yes, indicate date and type of operation. _____

Are you allergic to any medications? yes no. If yes, indicate medication(s):

_____ penicillin _____ tetracycline _____ sulfa _____ others(specify) _____

Are you presently taking any medication? yes no. If yes, list name of drug, dosage, strength, and frequency:

Do you wear contact lenses? yes no

5/00

(over)

IMMUNIZATION RECORD

Date Administered (month/day/year)

Diphtheria, Tetanus and Pertussis #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___

Oral Polio Vaccine #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

MMR (measles, mumps, rubella) #1 ___/___/___ #2 ___/___/___

Chickenpox #1 ___/___/___ #2 ___/___/___

Hepatitis B #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Have you had a tuberculin skin test? yes no. If yes, indicate date_____. Result: Pos. Neg.

If tuberculin skin test was positive, have you had a chest x-ray? yes, date:_____. Result:_____.
 no

If you are an international student or have lived outside of the United States, have you received BCG? (Vaccine for Tuberculosis) yes no

Have you lived in a household with anyone who had tuberculosis? yes no. If yes, please explain:_____

Medical personnel of the Caudill Health Clinic will review this health history. You will be notified in writing if further medical information is needed.

Name of Personal Physician:_____ Phone:_____ FAX:_____

I certify that all information is true and correct to the best of my knowledge. I also consent to examination and treatment by Morehead State University Caudill Health Clinic staff. This consent shall be continuing until revoked in writing.

signature of student

date

Additional Information Person to be notified at patient request in case of illness:

_____ Day phone _____ Evening phone _____
last first area code area code

Relationship to student? parent guardian spouse other _____

Insurance Information Most services of the Caudill Health Clinic are free. Minimal fees may be charged for some lab tests and services such as the Family Planning Clinic and program related physicals. Any fees charged in the Caudill Health Clinic are the responsibility of the student. We do not do third party billing. **In instances when referrals are made from the Caudill Health Clinic to specialists, private physicians, or hospitals, insurance information is often requested. Students, please carry a copy of your insurance card with you.**

Medical Consent – for minors only (under 18 years of age)

I hereby consent to having qualified medical personnel render to my son or daughter medical and emergency treatment and/or surgical care, and services offered through University Counseling Center, as deemed necessary to his or her health and well-being. I grant permission for the hospitalization of my son or daughter when necessary for implementing proper medical care.

I also grant permission for Morehead State University Caudill Health Clinic to use and disclosure health information about my son/daughter in order to carry out treatment, payment, and health care operations as stated in Authorization and Notice of Medical Information Disclosure and Access.

Signature of parent/guardian

Date