Morehouse College
Division of Student Affairs
Student Health Services Pre Entrance

Health Record 2016

Please complete in ink or type only! Faxes or copies will not be accepted.

Deadline for Submission:

Fall Semester: June 1
Spring Semester: December 1

Return To:

Student Health Services
Brazeal Hall Box 140064
Morehouse College
830 Westview Dr. SW
Atlanta, Georgia 30314
(404) 215-2637

The Pre-Entrance Health Record is required before you are allowed to move in to campus housing or enroll at Morehouse College. The student, your parent/guardian and your doctor must complete this Pre-Entrance Health Record.

- Failure to provide important medical information could result in unnecessary lab tests or screenings.
- Incomplete pages and responses will result in the booklet being returned to you. Please make copies of the completed Pre-Entrance Health Record for your records and mail the originals.

PART I
To be completed by the Student and Parent
Authorization to Treat and Emergency Information

Clearance to move in to campus housing or registration for classes will not be granted until all Pre-entrance health requirements have been met. Please return this completed form to: Student Health Services, Morehouse College, Box 140064, 830 Westview Dr., Atlanta, GA 30314

NAME_____
Last **First** **MI**

PERMANENT HOMEADDRESS_____

_____
City **State** **Zip** **Country**

Social Security Number_____ **HOME PHONE NUMBER**_____**CELL PHONE**_____

EMAIL ADDRESS_____

DATE OF BIRTH_____ **AGE**_____ **Morehouse ID#**_____

ENROLLMENT DATE (Semester/Year) FALL/_____**Spring/**_____

ENROLLMENT CLASSIFICATION: ☐**Regular F/T** ☐**Regular P/T** ☐**International** ☐**Transfer**

☐**Pauline E. Drake Scholars** ☐**Guest**

☐**Exchange/International** ☐**Exchange-Domestic**

AUTHORIZATIONS: (Parent or legal guardian MUST sign if under 18 years of age) I hereby accept financial responsibility for the expense of health care services and I authorize the medical providers of Morehouse College Student Health Services and their agents or consultants, including emergency medical technicians, area hospitals or other treatment facilities, to perform diagnostic and treatment procedures, on the above named student, which in their judgment may become necessary while she attends Morehouse College. I have no expectation for Morehouse College to pay medical expenses for the student should he need treatment outside of Student Health Services. I agree to absolve and hold harmless Morehouse College in making medical decisions for the student. I understand that every effort will be made to notify the parent or legal guardian once permission is obtained from the student in the event of a major illness or injury. I understand that the parent or guardian may not necessarily receive notification prior to treatment.

Students Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

EMERGENCY CONTACT PERSON:

NAME _____ RELATIONSHIP_____

ADDRESS_____

DAY TIME PHONE NUMBER ( ) _____ NIGHT TIME PHONE NUMBER ( ) _____

[TO BE COMPLETED BY STUDENT HEALTH SERVICES PERSONNEL]

Status: **Complete** ☐ Reviewed By: _____ Date_____

Incomplete ☐ Checklist Indicating Missing Information Sent 1st Date Returned _____ 2nd Date returned_____

PART II
MUST BE COMPLETED BY MEDICAL PROVIDER

Name of Student: _____

This form must be completed and signed by your health care provider based on an examination date no earlier than August 1, 2015. *All ITEMS ARE REQUIRED!!*

DRUG ALLERGIES: ☐ Yes ☐No I f yes to what? ☐PCN ☐Sulfa ☐Erythromycin ☐other_____

If yes, what is the nature of the reaction? _____

FOOD ALLERGIES: ☐Yes ☐No, if yes to what?_____

If yes, what is the nature of the reaction?_____

Blood Pressure_____ Pulse_____ Height_____Weight _____BMI_____

REQUIRED TESTS and IMMUNIZATIONS
SCREENING FOR TUBERCULOSIS (Within the past 12 months)

The PPD skin test must be **placed and read** before the student will be allowed to move into campus housing. NOTE: If PPD is greater than 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment or other TB prophylaxis treatment should be initiated. *NOTE: PPD test should be mantoux within the past year (*tine or momovac not acceptable).*

	Date Placed	**Date Read**	**Results**	
PPD*	_____	_____	_____	_____

If positive, provide _____mm induration (horizontal diameter) N o t e *: If greater than 10mm induration, chest X-ray required*. X-Ray results: ☐ Normal ☐ Abnormal.

If chest x-ray is abnormal, has patient begun INH treatment or other TB prophylaxis treatment? ☐Yes ☐ No

If no, please explain _____

Received BCG: ☐Yes ☐ No If yes, chest X-Ray required. X-Ray results: ☐ Normal ☐Abnormal.

All immunizations and/or lab/serology tests are required unless otherwise noted. Your physician or medical provider must complete this record. The signature and office stamp of your physician or medical provider below must verify all immunizations. This record must be in ENGLISH. You may submit copies of immunization records and lab/serology test as proof of vaccine, history of disease or immunity.

IMMUNIZATIONS

MONTH/DAY/YEAR

MENACTRA VACCINE _____/____/_____
(Required)

VARICELLA VACCINE 1st vaccine _____/____/_____
(2 doses required) 2nd vaccine _____/____/_____
OR
OTHER IMMUNITY: Student had chickenpox disease _____/____/_____
OR
Laboratory/serology test for evidence of immunity _____/____/_____
Note: if the test is NON-REACTIVE, You MUST receive the Varicella vaccines ☐**Reactive** ☐**Non-Reactive**

HEPATITIS A VACCINE 1st vaccine _____/____/_____
(2 doses required) 2nd vaccine _____/____/_____
OR
Laboratory/serology test for evidence of immunity
Note: if the test is NON-REACTIVE, You MUST receive the HEPATITIS A vaccines ☐**Reactive** ☐**Non-Reactive**

HEPATITIS B VACCINE 1st vaccine _____/____/_____
(3 doses required 2nd vaccine _____/____/_____
OR 3rd vaccine _____/____/_____
Other Means of Obtaining Proof of Immunity
Laboratory/serology test for Hepatitis B surface antigen antibody:
Obtain if uncertain about dates of your Hepatitis B vaccines ☐**Reactive** ☐ **Non-Reactive**
Note: if the test is NON-REACTIVE, you must receive the Hepatitis B vaccines.

M.M.R (MEASLES, MUMPS AND RUBELLA 1st vaccine _____/____/_____
(2 doses required) 2nd vaccine _____/____/_____
OR
Student born before 1957 is considered immune. <Date of Birth> _____/____/_____
Other Means of Obtaining Proof of Immunity
Laboratory/serology test for evidence of immunity: ☐**Reactive** ☐ **Non-Reactive**

Obtain if uncertain about dates of vaccine or disease
Note: if the test is NON-REACTIVE, You MUST receive the MMR vaccines.

TETANUS, DIPHTHERIA (Tdap) or (Td) _____/_____/_____
Within the last 10 years

MEDICAL HISTORY AND DOCUMENTATION OF NEED FOR SPECIAL ACCOMODATION

Specific requests for accommodations must be initiated by completing the **Counseling & Disability Services Verification and Request for Accommodation** form.

Please list all prescription and nonprescription medications as well as dosages this student currently takes_____

Is this student receiving treatment or care for any acute or chronic medical condition? ☐Yes ☐ No If yes, please explain

_____

Does this student require special accommodations because of any chronic medical condition? ☐Yes ☐ No If yes, what is the medical condition and the special accommodations required _____

_____

Is this student receiving therapy for any emotional or psychiatric condition? ☐Yes ☐ No If yes, please explain _____

_____

Does this individual require special accommodations because of the emotional or psychiatric condition? ☐Yes ☐ No If yes, what accommodations are required?_____

_____

Has this individual had any surgical procedures? ☐Yes ☐ No If yes, please explain

_____

Are there any learning disabilities or learning challenges that require medication for management? ☐Yes ☐ No If yes, please explain indicating medication, dosage and frequency

_____

_____

Does the student have food issues requiring special diet? ☐Yes ☐ No If yes, please explain the nature of the food issue and specific diet required _____

_____

May the student participate in an athletic, sports or college wellness program? ☐Yes ☐ No If no, please explain?_____

_____

(Required – May not be signed by a family member)

M.D./D.O./N.P./P.A.'s Name (please print)_____

Signature_____

Address_____

Date of Exam_____Telephone number ( )_____

PART III

FITNESS RECORD

Please answer each question to the best of your ability. Your answers will help us better serve your fitness needs as a new student.

□ None (No exercise activity)
□ Light (Slow walking, limited activity, non-structured exercise)
□ Moderate (Cardiovascular exercise (walk, run, aerobic, yoga, etc.) for thirty (30) minutes, days per week?

1-2 _____
3-4 _____
5 _____
6-7 _____

□ Heavy/Intense (Walk 30-40 minutes, 3-4 or more times per week, structured exercise, weight training days per week?)

1-2 _____
3-4 _____
5 _____
6-7 _____

□ Strength, (Resistance training, days per week?)

1-2 _____
3-4 _____
5 _____
6-7 _____

If you participated in a formal wellness class, what would be accomplished by participating in a fitness program? (Please check all that apply.

□ Reduce Pain
□ Increase Strength
□ Increase Function
□ Return to Full Activity
□ Improve Posture
□ Prevent Surgery
□ Improve Flexibility
□ Lose Weight:_____lbs
□ Increase Cardiovascular Endurance
□ Gain Weight:_____lbs
□ Prepare for Surgery
□ Other: _____

On average, how many fruits and vegetables do you consume daily?

0 servings per day _____
1-2 servings per day _____
3-4 servings per day _____
5 or more servings per day _____

How much water do you drink daily?

Ounces _____
Glasses _____

On average, how much sleep do you get each night>

Less than four (4) hours _____
Four (4) to five (5) hours _____
Six (6) to seven (7) hours _____
More than seven (7) hours _____

Do you struggle to say awake in the daytime?_____Yes_____No

Student Health Insurance

Morehouse College requires all degree-seeking students to have health insurance or purchase the College sponsored plan. All students are charged for the college-sponsored plan up front, however you may elect to waive or opt out of this plan.

In order to **"opt out of enrollment"** in the college sponsored plan, students and families must provide evidence of current enrollment in a health insurance plan licensed to do business in the United States, with a claims payment office with a U.S. phone number and offers an Annual Maximum comparable to the student health insurance offered by the college.

This coverage includes medical and mental health care, within the Atlanta area, that extends beyond **emergency-only** coverage and covers pre-existing conditions as well as prescription drugs.

If you do not wish to purchase the college sponsored plan, you **must opt out or waive the plan by** the deadline of **July 30, for fall enrollment** and **December 20 for spring enrollment.**

If your request to waive or opt out is declined, you will receive notification through the email address you used to complete the waiver along with instructions to appeal by printing the **"Appeal/Insurance Verification"** form and submitting this to your insurance carrier.

Failure to opt out or waive the college sponsored student health insurance plan will result in this fee being added to the student's account. If you wish to enroll in the college-sponsored plan, do nothing; the fees will be added to your account!

MEDICAL INSURANCE INFORMATION

Insurance Company Name: _____

Address_____
Street City State Zip

Telephone: (____)_____ Policy#_____

Group#_____ Identification#_____