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

Deadline for Submission:  
Return To:  
Fall Semester: June 1  
Student Health Services  
Spring Semester: December 1  
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 ____________________________________________ ____________________________

PERMANENT HOME ADDRESS ______________________________________________________

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 ☐ Incomplete ☐ Review By: ____________________________ Date ____________________________

☐ Checklist Indicating Missing Information Sent 1st Date Returned ____________________________ 2nd Date returned ____________________________
Morehouse College: Pre-Entrance Health Record

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 ALLERGENIES: □ Yes □ No If yes to what? □ PCN □ Sulfis □ Erythromycin □ Other __________________________

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

FOOD ALLERGENIES: □ 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 (line or momovac not acceptable).

<table>
<thead>
<tr>
<th>Date Placed</th>
<th>Date Read</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD*</td>
<td></td>
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</tr>
</tbody>
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If positive, provide ____________ mm induration (horizontal diameter) Note: 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

MENACTRA VACCINE
(Required)

VARICELLA VACCINE
(2 doses required)
1st vaccine
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

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

HEPATITIS B VACCINE
(3 doses required)
1st vaccine
2nd vaccine
3rd vaccine
OR
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
Note: If the test is NON-REACTIVE, you must receive the Hepatitis B vaccines.

M.M.R (MEASLES, MUMPS AND RUBELLA)
(2 doses required)
1st vaccine
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:
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 ______

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 ______
Six (6) to seven (7) hours ______
Four (4) to five (5) hours ______
More than seven (7) hours ______

Do you struggle to stay 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#____________________________