

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

Return To:

**Student Health Services
Brazeal Hall Box 140064
Morehouse College
830 Westview Dr. SW
Atlanta, Georgia 30314
(470) 639-0603**

The Summer Academy Health Record is required before you are allowed to move in to campus housing or participate in a Morehouse College summer program. The participant, parent/guardian, and your doctor must complete this Health Record.

- Incomplete pages and responses will result in non-participation. Please make copies of the completed Health Record for your records and mail the original to the address above.

PART I

Student/Parent Authorization to Treat and Emergency Information

Clearance to move in to campus housing will not be granted until all pre-entrance health requirements have been met.

NAME Last First MI

PERMANENT HOMEADDRESS

City State Zip Country

SSN # HOME PHONE CELL PHONE

EMAIL ADDRESS

DATE OF BIRTH AGE MOREHOUSE ID#

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 he 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.

Student Signature Date

Parent/Guardian Signature Date

EMERGENCY CONTACT PERSON:

NAME RELATIONSHIP

ADDRESS

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

Secondary Emergency Contact

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 Checkiist 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. ALL ITEMS ARE REQUIRED!!

DRUG ALLERGIES: Yes No If 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 _____

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 _____

Physician Signature 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 () _____

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 medications and nonprescription medications this student currently takes, as well as the dosage.

REQUIRED 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) 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

MEDICAL INSURANCE INFORMATION

Insurance Company Name: _____

Address _____
 Street City State Zip

Telephone: (____) _____

Policy Holder Name: _____

ID Number: _____ Group Number: _____

CERTIFICATE OF IMMUNIZATION

Retain a copy of the completed form for your records.

STUDENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Year of Application: _____ Age at time of application: _____ Date of Birth (mm/dd/yyyy): ____/____/____

REQUIRED IMMUNIZATION INFORMATION

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR ¹	/ /	/ /			
Hepatitis A ²	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /
Meningococcal ACWY ^{4,5} (MCV4)	/ /	/ / MCV4 Booster ⁶			
Meningococcal B ⁶	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	
Varicella ²	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough) ³	/ / Tdap	/ / Td Booster ³			
Hepatitis B ²	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /

1—Not required if born before 1957. 2—Required for all US born students born in 1980 or later; all foreign born students regardless of year born. 3 – Td booster only necessary if > 10 years since Tdap dose. 4 – Required if residing in campus housing, sorority housing, or fraternity housing. 5 – MCV4 Booster necessary if initial MCV4 dose was received more than 5 years to admittance. 6 – Consider if younger than 23 years of age.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

- This student is exempt from the above immunizations on the ground of permanent medical contraindication.
- This student is temporarily exempt from the above immunization until ____/____/____ (mm/dd/yyyy)

CERTIFICATION OF HEALTH CARE PROVIDER *(This information is required)*

Name: _____ Signature: _____

Address: _____

Date of Issue: ____/____/____ Telephone: _____

Waiver, Release and Indemnification

We the undersigned request that _____ (“Participant”) be granted permission to participate in _____, to be held at Morehouse College from _____, to _____, (“Activity”).
Name of program
Month/Day/Year Month/Day/Year Month/Day/Year Month/Day/Year

In consideration of the Participant’s being permitted to participate in the Activity, we do release, waive, forever discharge and covenant not to sue Morehouse College, it’s governing board, officers, agents, employees and any students acting as employees (“Releases”), from and against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs, and expenses of any nature which Participant or his or her Parent or Guardian, arising out of or related to any loss, damage or injury, that may be sustained by Participant or by any property belonging to Participant or his or her Parent or Guardian, whether caused by the negligence or carelessness of the Releases, or otherwise while Participant is in, on, upon or in transit to or from the premises where the Activity, or any adjunct to the Activity, occurs or is being conducted.

We further state that there are no health--related reasons or problems which precludes or restrict Participant’s participation in this Activity, and that Participant has or will have adequate health insurance necessary to provide for and pay any medical costs that may be attendant as a result of any injury to the Participant.

It is our express intent that this Waiver, Release and Indemnification Agreement shall bind the members of Participant’s family and spouse if married. Participant and/or Participant’s parent/guardian further agree to save and hold harmless, indemnify and defend the Releases from any claim by Participant’s family arising out of Participant’s participation in this Activity.

Participant further agrees to abide by the rules and regulations of the College while participating in this Activity and acknowledges and recognizes the right of Morehouse College, through its employees or agent, to terminate his or her participation in this Activity should (s)he not abide by the stated regulations. Participant agrees to supply a signed copy of this document to his or her parent or guardian.

We further agree that this release shall be construed in accordance with the laws of the State of Georgia. If any term or provision of this Release shall be held illegal, unenforceable or in conflict with any law governing this Release, the validity of the remaining portions shall not be affected.

I, Participant’s Parent/Guardian further state that I am the Participant’s Parent/Guardian, and am fully competent to sign this Agreement, and that I execute this release for full, adequate and complete consideration of my own free act and deed, fully intending for myself, for the Participant and for the Participant’s family, estate, heirs, personal representative or assigns to be bound by the same. No oral representation, statements, or inducements, apart from the foregoing have been made.

THIS IS A RELEASE OF LEGAL RIGHTS, READ BEFORE SIGNING.

Parent/Guardian (Signature) Date

Witness (Signature)

Address Date

Student/Participant (Signature) Witness (Signature)

No student will be allowed to participate in the Summer Academy Program unless this form has been received prior to or upon arrival, or otherwise designated by the Program Director. If you have not already done so, please return the form to the Director of the Program in which you will participate.