Morehouse College: Pre-Entrance Health Record | 2017

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**

SSN #_______________ **HOME PHONE**_______________ **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** □**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 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 □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. ***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) 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

REQUIRED SCREENING FOR SICKLE CELL

Sickle Cell Results: ☐ Normal ☐ Trait ☐ Disease

Sickle Cell date of test: ____________________

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 (   )______________

CERTIFICATE OF IMMUNIZATION

Retain a copy of the completed form for your records.

STUDENT INFORMATION

Student ID:____________________-____________________- ________________________

Name: (Last)________________________________(First)____________________________(Middle)______________________

Address:____

City:__________________________________State:________________Country:___________________Zip Code:____________________

Term/Year of Application: Age at time of application:_________Date of Birth (mm/dd/yyyy):____/__________/__________

REQUIRED IMMUNIZATION INFORMATION *(See the Immunization Requirements & Recommendations for USG Students documentation)*

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: ☐ 2 Dose Series ☐ 3 Dose Series	/ /
Meningococcal ACWY [4,5,6,7] (MCV4)	/ /	/ / MCV4 Booster [6]			
Meningococcal B [6]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	
Varicella [2]	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough) [3]	/ / Tdap	/ / Td Booster [3]			
Hepatitis B [2]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 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: ____

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 a fee being added to the student's account. If you wish to enroll in the college-sponsored plan, do nothing; the fee will be added to your account!

MEDICAL INSURANCE INFORMATION

Completion of this portion of the form does **NOT** serve as the waiver/opt-out form

FOR USE BY STUDENT HEALTH SERVICES ONLY

Insurance Company Name: ____

Address____

Street City State Zip

Telephone: (____)____________________

Policy Holder Name:____

ID Number:____________________________________ Group Number:____________________________