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: Return To:
Fall Semester: June 1 Student Health Services
Spring Semester: December 1 Morehouse College
Brazeal Hall Box 140064
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.
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!
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 I.D.# __________________________

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 ( ) ___________________________

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[TO BE COMPLETED BY STUDENT HEALTH SERVICES PERSONNEL]

Status: Complete [ ] Reviewed By: __________________________ Date __________________________
Incomplete [ ] Checklist Indicating Missing Information Sent __________________________ 2nd Date returned __________________________

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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, 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 ________________

**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).

<table>
<thead>
<tr>
<th>Date Placed</th>
<th>Date Read</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENACTRA VACCINE (Required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARICELLA VACCINE (2 doses required)</td>
<td></td>
<td></td>
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<tr>
<td>Other Immunity: Student had chickenpox disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory/serology test for evidence of immunity</td>
<td></td>
<td></td>
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<tr>
<td>Note: if the test is NON-REACTIVE, you MUST receive the Varicella vaccines</td>
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<tr>
<td>HEPATITIS A VACCINE (2 doses required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory/serology test for evidence of immunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: if the test is NON-REACTIVE, you MUST receive the HEPATITIS A vaccines</td>
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<td></td>
<td></td>
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<tr>
<td>HEPATITIS B VACCINE (3 doses required)</td>
<td></td>
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<td></td>
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<tr>
<td>Other Means of Obtaining Proof of Immunity</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>M.M.R (MEASLES, MUMPS AND RUBELLA (2 doses required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student born before 1957 is considered immune.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other Means of Obtaining Proof of Immunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TETANUS, DIPHTHERIA (Tdap) or (Td)</td>
<td></td>
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</tbody>
</table>

### 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  ☐ Improve Posture  ☐ Increase Cardiovascular Endurance
☐ Increase Strength  ☐ Prevent Surgery  ☐ Gain Weight: _____ lbs
☐ Increase Function  ☐ Improve Flexibility  ☐ Prepare for Surgery
☐ Return to Full Activity  ☐ Lose Weight: _____ lbs  ☐ 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