Morehouse College: Summer Academy Health Record 20_____

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 □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 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_____

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.

_____
_____
_____
_____

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: _____ Zip:_____

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: ☐ 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	/ /

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

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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
Name of program
College from_____, to_____, ("Activity").
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

_____ _____
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.