BREWTON-PARKER COLLEGE
HEALTH/MEDICAL QUESTIONNAIRE

HEALTH HISTORY

Student Name: ______________________________
(PLEASE PRINT CLEARLY)

SSN:_____/_____/_______ Sex: _____F _____M

Date of Birth: ___/____/_____ Weight: ____ Height: ____

This form must be completed and returned prior to moving into the residence hall. Please return form to:

Department of Residence Life
Brewton-Parker College
P.O. Box 197
Mt. Vernon, GA 30445

EMERGENCY CONTACT INFORMATION

Name: ______________________________

Address: ______________________________

City, State and ZIP: ______________________________

Home Telephone: ______________________________

Work Telephone: ______________________________

Relationship to Student (Parent or Legal Guardian): ______

Have you ever or are you currently being treated for the following:

___Heart Problems
___Frequent or Severe Headaches
___Fainting Spells or Dizziness
___Epilepsy or Convulsions
___Ear, Nose, or Throat Problems
___Blood Disorder (e.g. Anemia)
___Drug or Alcohol Problems
___Handicap (Explain)
___Rheumatic Fever
___Asthma
___Hay Fever
___Diabetes
___Depression/Mental Illness
___High/Low Blood Pressure
___HIV/AIDS

Please list any and all medications you are currently taking (including Rx medications, over the counter medication, and herbal medicine):

History of major illnesses or injury (attach extra sheet if needed):

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

In case of serious illness or accident, I give Brewton-Parker College or its representative(s) permission to secure medical care, which may include transportation to a doctor or hospital. I understand that I am financially responsible for any and all expenses incurred.

I have read, understand, and agree with the above statement.

Student:____________________________ Date:___________

Parent/Guardian:____________________ Date:___________

TO BE COMPLETED BY STUDENT AFFAIRS OFFICE:
Insurance Company:______________________________
Policy Holder:______________________________
Policy Number:______________________________
Insurance Company Phone Number:______________________________

PHYSICAL EXAM

A PHYSICIAN MUST COMPLETE THIS PORTION:

Treating Physician: ______________________________
(PLEASE PRINT CLEARLY)

Physician's Telephone Number: ______________________________

Physician's Office Address: ______________________________

____

Blood Pressure: ______________ Pulse: ______________

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose Throat		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

Date of the following immunizations:

MMR1: ____________________ MMR2: ______________

TB Skin Test (most recent): ______________________________

Documentation of Disease: ______________________________

Laboratory Titers: ______________________________

Tetanus Shot (most recent): _______ Hepatitis A/B (optional): ________

Meningococcal Vaccine (optional but encouraged for all freshmen): ________

- ❑ Cleared: I recommend student to participate in intramural and intercollegiate sports.
- ❑ Not Cleared: I do not recommend student to participate in intramural and intercollegiate sports.
- ❑ Cleared after completing evaluation / rehabilitation for:

____

____

Comments:

Physician's Signature: ____________________ Date: ________

It is imperative that any important history concerning the patient's health be included, and if necessary, attached. If the student is under 18, the parent or legal guardian for the student must sign the Authorization for Treatment and Release section of this form in order for the student to receive treatment from area hospitals or doctors. ***All information is confidential.***