

MARSHALL UNIVERSITY STUDENT HEALTH FORM

The information provided below is requested of ALL new students enrolling in Marshall University. It will be kept confidential and on file only in the Marshall University Student Health Service. Your record will be used to provide the best possible care for you should you become sick or injured while on campus.

Name (print) _____ Social Security No. _____
Last First Middle

Campus Address: _____ Phone: _____

Home Address: _____ Home Phone: _____

Street City State Zip
 Year Enrolled _____ Marital Status _____ Date of Birth _____ Race _____

Sex: Male ___ Female ___ Academic Rank: _____
Fresh. Soph. Junior Senior Grad. Special

In case of Emergency notify _____
Name Relationship

Address _____
Street City State Zip

Home phone _____ Work phone _____

Do you or your guardians have health insurance? _____ Name of insurance co. _____

PLEASE CHECK APPROPRIATE BOX

Do you or have you had a medical history of:

- Cardiac problems (heart)
- Breathing problems
- Kidney problems
- Stomach problems
- Diabetes (sugar)
- Hemophilia, Sickle Cell diseases
- High Blood Pressure
- Low Blood Pressure
- Hypoglycemia (low blood sugar)
- Migraine headaches
- Emotional problems
- Epilepsy
- Gynecological problems
- Permanent disability (please specify) _____
- Other pertinent medical problems _____

- Thyroid Disease
- Glaucoma
- Tuberculosis
- Liver Disease
- Cancer
- Anemia
- Mononucleosis

- Immunizations:
- Measles
 - Mumps
 - Rubella
 - Tetanus

Are you allergic to:

- Medications (specify) _____
 - Foods (specify) _____
 - Insect bites (specify) _____
 - Other (specify) _____
- Allergies:
- Asthma
 - Hay Fever
 - Skin (specify) _____

Date Last Immunized _____

Have you ever been hospitalized? _____ Reason _____ Date _____

If you have had surgery specify _____

If you are on regular medication specify _____ Birth Control Pills _____

Date of last tetanus shot _____

STATEMENT OF AUTHORIZATION

I authorize and request the Marshall University Student Health Service to administer out-patient medical, surgical services and immunizations and to perform emergency procedures, as necessary, or to refer to duly licensed medical personnel when indicated, including transfer to outside hospitals.

Also, I authorize any physician, healer, practitioner, clinic or hospital to furnish to the Marshall University Student Health Service all information concerning my case history and the treatment, examination or hospitalization which I received in the past, including copies of hospital and medical records.

In addition, I authorize the Marshall University Student Health Service to disclose to the Physical Education Department of Marshall University such medical information as is required for the sole purpose of placing me into an appropriate physical activity class in so far as my health and physical well being permit.

I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural and intercollegiate athletics unless otherwise noted in this health inventory.

Signature of student

Signature of parent or guardian if under legal age of adulthood in W.Va.

Date: _____ Date: _____