

Student's Medical History

University of Montevallo Student Health Services
Station 6275, Montevallo, AL 35115-6000 (205) 665-6275
FAX (205) 665-8180

Side A

This medical history form must be completed in order to enroll in classes. Personal medical history is required of all students (off-campus and on-campus, full-time and part-time). The completed form must be returned to the above address prior to registration. All information is considered confidential.

To Be Completed By Student

Full Name: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

Parent/Guardian: _____

Address: _____

Telephone (in case of emergency): _____

Plan to enroll at the U of M beginning the following term:

For year _____ Fall Term Spring Term

May Term Summer 1 (June) Summer 11 (July)

Insurance Carrier: _____

Policy Number (required): _____

Family Physician: _____

Address: _____

Physician's Office Phone: _____

Personal Medical History

Check the box if you have had the disease listed:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Whooping Cough | |

International (foreign national) students:

- | | |
|--|--|
| <input type="checkbox"/> Yellow Fever | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> BCG (TB skin test required) | |

Special Concerns – Check and respond as appropriate

- | | |
|--|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Auditory _____ |
| <input type="checkbox"/> Cerebral Palsy _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Heart _____ |
| <input type="checkbox"/> Kidney _____ | <input type="checkbox"/> Ulcers _____ |
| <input type="checkbox"/> Visual _____ | <input type="checkbox"/> Wheel Chair _____ |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Allergies (specify): _____ | |
| <input type="checkbox"/> Injuries (specify): _____ | |
| <input type="checkbox"/> Surgery (specify): _____ | |
| <input type="checkbox"/> Family illness (specify): _____ | |

AUTHORIZATION

I hereby authorize the University of Montevallo to provide general health care and/or obtain services of and/or advice from a physician of its choice in case of illness or emergency, including any necessary transportation of student for such care. I hereby also assume all responsibility for the costs beyond that provided in the Student Health Center or that is specified under coverage of the semester health fee. The University reserves the right to contact parents/family where deemed appropriate. All statements in this medical record are true to the best of my knowledge and belief, and I have no abnormality, limitation, or restriction not mentioned in this record. Should any change in my health status occur, I understand that Student Health Services should be notified in writing.

Signature* _____
Parent/Guardian or Student

Relationship to Student _____

*Must have signature before health services can be rendered.

Date _____

Student's Medical History

To Be Completed By Physician

Student's Name: _____ Date of Birth: _____

Medication Allergies: _____

VACCINATIONS (INCLUDE DATES ADMINISTERED OR ATTACH COPY OF IMMUNIZATION RECORD)

Measles (required if born in or after 1957)

first dose: _____

second dose: _____

Tuberculosis Test Results _____
(International students must have results in millimeters)

Name of Test _____

Date of Test _____

Diphtheria _____

***International students are required to have a TB skin test or chest x-ray done within 12 months prior to attending the University.**

Oral Polio-required (booster not necessary) _____

Tetanus (required within five years) _____

Physician's Assessment

Subjects	Normal	Abnormal	Comments
Eyes			
Vision			
Ears			
Nose			
Tonsils			
Teeth			
Thyroid			
Cervical Glands			
Breast			
Lungs			
Heart			
Abdomen			
Skin			
Extremities			
Hemoglobin			
Blood Pressure			
Other Physical Defects			

List Current Medications:

Any restrictions on physical activity? _____ Yes _____ No

If yes, please explain and recommend any permitted activity: _____

How long have you known the student? _____ Most recent examination: _____

Other health-related recommendations or restrictions: _____

On the basis of your examination and knowledge, do you believe the student is physically and emotionally able to participate in a full program of college-level study and related activities? _____ Yes _____ No

Signature of Physician: _____

Address: _____

Office Telephone: _____