

**To be completed by new students.**

Full Name \_\_\_\_\_ Gender:  M  F Age: \_\_\_\_\_  
First Middle Last

Home Address \_\_\_\_\_  
Street City State Zip

Phone ( ) \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_ Expected Date of Enrollment \_\_\_\_\_  
(optional)

Name of Parent, Guardian or Spouse (circle one) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

### Health Insurance Information

*\*Please submit a copy of both sides of insurance ID card*

Name of Ins. Co. \_\_\_\_\_ Pol./ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ Plan No. (if applicable) \_\_\_\_\_

### Health History

*Please check conditions below which pertain to your current or past medical history.  
 Utilize the space provided to explain those areas identified.*

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> Cancer                | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problems            |
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Psychiatric Care or Problems |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Depression            | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Appendicitis      | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Major Surgery       | <input type="checkbox"/> Sickle Cell Anemia           |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Measles             | <input type="checkbox"/> Stomach Ulcers               |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Fractures             | <input type="checkbox"/> Menstrual Problems  | <input type="checkbox"/> Strokes                      |
| <input type="checkbox"/> Back Problems     | <input type="checkbox"/> Glaucoma or Cataracts | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> Bladder Problems  | <input type="checkbox"/> Goiter                | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Tonsillitis                  |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Breast Lumps      | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Mumps               |   |
| <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Pneumonia           |   |
| <input type="checkbox"/> Bulimia           | <input type="checkbox"/> Hernia                | <input type="checkbox"/> Polio               |   |

Current Medication(s): \_\_\_\_\_

Current Health Problems and Past Health Problems: \_\_\_\_\_

Allergies (Medications, Foods, Substances, etc.): \_\_\_\_\_

Explanation of Identified Conditions: \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

### Student Treatment Consent

In case of serious illness or accident, I give Union University or its representative(s) permission to secure medical and/or surgical care to include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a condition requiring minor care, I give my permission for treatment to the college physician or his staff.

All statements in this medical record are true to the best of my knowledge and belief. Should any change in my health status occur I understand that Student Health Services should be notified in writing.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian's Signature (if student is under 18) \_\_\_\_\_ Date \_\_\_\_\_

### Consent for Release of Information

In order to provide continued and appropriate medical care, I give Union University or its representative(s) permission to release personal health information to health care professionals/medical facilities by E-mail, FAX, phone.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_