Student Wellness Center Health Services

Medical Questionnaire

Please read other side before completing this form

Student Information

Name: ____ Date of Birth: ____________________
(Last) (First) (Middle)

Social Security Number: ______________________________ Height ______ Weight ______ Male _____ Female _____

Permanent Address: ____
(Street) (Apt.) (City) (State/Province) (Zip/Postal Code) (Country)

Permanent Telephone: ______________________________ Cell Phone: ______________________________

Emergency Contact Name:______________________________ Address: ______________________________

Emergency Contact Telephones: Home ____________________________ Work/Cell: ______________________________

Medical Services

Primary Care Physician: ______________________________ Telephone: ______________________________

Office Address: ____

Health Insurance: ____
(Company, Policy #, Group #, Co-pay information) (Please include a photocopy of your insurance ID)

Medical Information

Past Medical History, including Chronic Medical Problem(s) or Disability: ______________________________
____
____
____

Past Surgical History: ____

List all prescription and over-the-counter medications you are taking:

Medication	Dosage & Frequency	Medication	Dosage & Frequency
1.		4.	
2.		5.	
3.		6.	

Medication Allergies: ____

Environmental Allergies: ____

Family History of Significant Illnesses: ____

Do you drink alcohol?_______ If yes, amount, frequency and how long ______________________________
Do you smoke: ____________ If yes, amount, frequency and how long ______________________________
Do you use street/recreational drugs?_____ If yes, type, amount, frequency, and how long ____________________
____

Do you need special accommodations for a physical or learning disability? ____ If so, please describe your needs and also send copies of report(s) listing your diagnoses and any recommended accommodations to the Director of the Student Wellness Center: ______________
____

Would you like to talk with a Counselor or Dean about any personal concern or problem? ______________________________
____

Signature ____ **Date:** ______________________________

Student Wellness Center Health Services

Medical Questionnaire

Please read this information before completing form on the reverse side

Directions

On the other side of this form, you will be asked a series of questions relating to your medical history. Please print or type the information requested. Complete all items. Do not leave blank spaces. If the item does not apply, print NA for not applicable. Upon completion, please sign and date the form, and mail it along with your other health forms to Ms. Lora Helton, The Student Wellness Center, Student Health Services, Georgetown College, 400 East College Street, Georgetown, Kentucky 40324.

Confidentiality

This medical questionnaire is required from all Georgetown College students. Your information will be kept confidential, according to certain legal and ethical guidelines such as the Health Insurance Portability and Accountability Act (HIPAA). Your information will be available only to Student Health Services staff, supervisory medical staff of the Georgetown Community Hospital, and to persons you designate in writing with a signed release form. You will be provided a notice of confidentiality and privacy practices when you visit Student Health Services for your first visit. (If you would like a detailed copy of privacy and confidentiality practices sooner than your first visit, you may contact our staff, and we will send you a copy by mail. Our telephone is 502-863-8201.)

Mission of the Student Wellness Center and Student Health Services

The staff of the Student Wellness Center and Student Health Services are concerned with the good health of all students. In a college situation the good health of an individual is essential to performance and college community harmony. To this end, the college provides regular health services and reviews an individual's health situation as one consideration in making room assignments, advising, and counseling persons about the many activities and opportunities the college offers.

With this in mind, if you have a diagnosed medical condition that requires special housing or classroom attention, or other needed accommodations, please indicate this on the other side of this form. Please also sign below, signifying that you give permission for the staff of Student Health Services to contact appropriate persons on campus to alert them to your condition and to provide the help or accommodations you need. You should provide documentation of your condition to the Student Wellness Center Director in the form of a photocopy of official reports or a letter from your physician.

Release of Information for Students Who Have Disabling Condition(s) or Special Health Concerns

My signature below indicates that I give permission to Student Wellness Center staff to communicate with other college staff, as needed, to arrange housing, classrooms, and/or accommodations based on my diagnosed health condition(s). I will send copies of reports of my condition to the Director of the Student Wellness Center.

Signature ____ **Date:** ____________________________

Permission for Treatment if Student is Less than 18 years of Age

If you are less than 18 years of age, you will need to have a parent or legal guardian give permission for treatment. Please have the person print your name and sign below.

I give permission for ____ *to be treated at the Georgetown College Student Wellness Center Student Health Services.*

Parent or Guardian's Signature: ____ **Date:** ______________