

Current medications: _____

Current tobacco user? YES ___ NO ___ If yes, how many per week? _____

Past tobacco user? YES ___ NO ___ Alcohol user? YES ___ NO ___ If yes, how many per week? _____

Do you always wear a seat belt in an auto? YES ___ NO ___

How often do you exercise? _____

Will you need specific medical assistance or physical disability accommodations at college?

YES ___ NO ___ Explain: _____

Immediate Family History (mother, father, siblings)							
	Yes	No	Relationship		Yes	No	Relationship
Asthma/hayfever				Cancer (list type below)			
Depression/anxiety							
Diabetes							
Heart disease							
High blood pressure				Other			
Thyroid disease							

To the best of my knowledge, the above information is accurate. I understand the information I provided will be used to assist medical personnel in case of emergency.

Signature of student: _____ Date: _____