HEALTH CENTER
North Carolina Wesleyan College
3400 N. Wesleyan Boulevard
Rocky Mount, NC 27804
Phone: 252-985-5178
Fax: 252.985.5580

CONFIDENTIAL HEALTH FORM

STUDENT ID #

NAME Last First Middle Social Security Number Telephone Number

Street Address City State Zip Date of Birth

M / F Fall/Spring 20-

Cell Phone # Age Sex Proposed Registration Marital Status

Emergency Contact Person Relationship Telephone Number

ALLERGIES: (food, drugs, other) _____

PERSONAL HISTORY-PLEASE ANSWER ALL QUESTIONS **Comment on all yes answers in the space below**

HAVE YOU HAD:	Y	N		Y	N		Y	N		Y	N
Frequent or Severe Respiratory Infections			Tuberculosis			Kidney or Bladder Problems			**FEMALES ONLY**		
Ear, Nose, Throat Problems			Diabetes			Disease or Injury of Bones or Joints			Irregular periods		
Frequent or Severe Headaches			Anemia			"Trick" Knee, Shoulder etc.			Severe Cramps		
Rheumatic Fever or Heart Murmur*			Hepatitis or Jaundice			Mononucleosis			Excessive Flow		
Asthma, Hay Fever, Hives			Eye Problems								
Stomach or Intestinal Problems			Epilepsy								

*** If you checked yes to the question concerning rheumatic fever or heart murmur, please provide an attached statement from you physician describing current conditions with emphasis on whether full participation in physical education activities is advisable.**

Do you have any disease that should be periodically evaluated?
(Give details) Have you had any injury or operation or been hospitalized other than already noted? _____**YES** _____**NO**

Are you taking any medication on a regular basis?
(If yes, give details i.e., Acne, Birth Control, Inhaler, etc) _____**YES** _____**NO**

Is there any reason why you should limit participation in physical activities?
(If yes, please provide a statement from your physician describing your limitation.)
_____**YES** _____**NO**

COMMENTS (Use additional sheet of paper if necessary)

_____
_____
_____
_____
_____
_____
_____

STATEMENT BY THE STUDENT: I have personally supplied the above information and attest that is true and complete to the best of my knowledge. I hereby authorize and consent to any medical treatment advised or recommended by the licensed staff of the Health Center at North Carolina Wesleyan College. I understand that student medical information is confidential and is used for providing medical care. I hereby give my permission for NCWC Health Center to release and obtain medical information to/from physicians, hospitals, mental health agencies or medical agencies that will benefit my total mental and physical health care at NCWC. I also hereby give my permission for NCWC Health Center to release or obtain medical information to/from other colleges or universities.

Signature of Student: _____**Date:** _____

I give consent for the NCWC physician or nurse to discuss my medical condition with my parents, guardian or significant other. **Please initial yes or no.**

YES_____ **NO** _____

PARENTS OF STUDENTS UNDER AGE 18: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I hereby authorize and consent to any medical treatment for my son/daughter which may be advised or recommended by the licensed staff of the Health Center at North Carolina Wesleyan College. I understand that student medical information is confidential and is used for providing medical care. I hereby give my permission for NCWC Health Center to release and obtain medical information to/from physicians, hospitals, mental health agencies and medical agencies that will benefit my child's total mental and physical health care at NCWC. I also hereby give my permission for NCWC Health Center to release or obtain medical information to/from other colleges or universities.

Signature of Parent: _____ **Date:** _____

Revision Date: 4/2013