



UNIVERSITY OF WEST GEORGIA
University System of Georgia
HEALTH FORM

Name Last First Middle Initial Date of Birth

Address Street City State Zip

Sex SS# Anticipated Semester of Entry at UWG

Medical Insurance Policy Number

Name of Insured SS#

Address of Insurance Co.

Is a claim form necessary?

PLEASE COMPLETE ALL PORTIONS OF THIS FORM

Permission for Diagnostic and Treatment Procedures

I hereby authorize the physicians of the University Health Service and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures, which in their judgement may become necessary while at West Georgia.

STUDENT SIGNATURE Date

PARENT SIGNATURE Date

(If student under 18 years of age at time of enrollment) With this signature I waive all claim to prior notification. I understand that if, in the judgement of the professional staff, the student's parent or guardian should be notified, this will be done.

Persons to Notify in an Emergency Situation (preferably close relatives)

1. Name Relationship

Address Office Phone

Home Phone

2. Name Relationship

Address Office Phone

Home Phone

MEDICAL HISTORY

1. Do you have or have you had any of the following?

- Allergies Yes No Diabetes Mellitus Yes No Epilepsy/Convulsions Yes No
Asthma Yes No Heart Problems Yes No High Blood Pressure Yes No
Do you receive allergy shots? Yes No Periods of Unconsciousness Yes No Rheumatic Fever Yes No
Are you allergic to: Surgical Operations Yes No Tuberculosis Yes No
Chicken/Eggs Yes No Hepatitis Yes No Nervous/Emotional Problems Yes No
Other Foods Yes No Visual or Hearing Impairment Yes No Learning Disability Yes No
Penicillin Yes No Bleeding/Hemophilia Yes No Any Physical Disability Yes No
Other Drugs Yes No

2. IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE PLEASE DESCRIBE BELOW AND HAVE YOUR PHYSICIAN FORWARD A SUMMARY OF YOUR TREATMENT OF ANY CURRENT CONDITION TO CLINICAL DIRECTOR, WEST GEORGIA HEALTH CENTER, CARROLLTON, GA 30118. PLEASE LIST ANY DISABILITIES BECAUSE OF WHICH THE UNIVERSITY MAY NEED TO PROVIDE YOU WITH SPECIAL ASSISTANCE.

3. Do you take any prescribed medication on a regular basis? Yes No If yes, please list medications by name.

4. Tetanus Status: Tetanus Booster Date: (Should have received within past ten years)

5. Have you received the Meningococcal (meningitis) Vaccine: Yes No

If Yes, Date of Immunization

The information on this form is confidential and will be used only in matters concerning your health. Mail completed form to the appropriate office: Health Services, University of West Georgia, Carrollton, Georgia 30118-4700.