STATE UNIVERSITY OF WEST GEORGIA

University System of Georgia

HEALTH FORM

Name____ Date of Birth ____________
Last First Middle Initial

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.*

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   ____

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. Tuberculin Skin Test: (Should be administered within 6 months of arrival on campus) Date____________________
   Negative ❑ Positive ❑
   Chest X-ray (required if skin test is positive) Date ____________________ Negative❑ Positive ❑
   If positive give details of treatment ____
   ____

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, State University of West Georgia, Carrollton, Georgia 30118-4700.

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