UNIVERSITY of West Georgia.

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#_____ Phone No._____ Date 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.

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