GRAMBLING STATE UNIVERSITY
Grambling, Louisiana 71245

MEDICAL HISTORY

(Student Must Have Both Sides of This Record Completed)

Students are to complete the following form very carefully, for, in the event of a medical emergency, such information will be very valuable to us. All information is confidential, and is reviewed by Health Center Personnel only. Health records are VALID for four (4) years only.

PLEASE PRINT OR TYPE ALL INFORMATION, PLEASE USE INK.

Name _____ Sex _____ Birthdate _____
Last First Middle

Home Address _____
Street City State Zip

Home Phone _____ Social Security Number _____

Person to notify in the event of serious accident or illness:

Name _____ Address (complete) _____

_____

FAMILY HISTORY

Has any member of your family (including grandparents) ever had any of the following? (Please Check)

_____ Asthma or Hay Fever
_____ Convulsions
_____ Cancer
_____ Tuberculosis
_____ Diabetes
_____ Heart Disease
_____ High Blood Pressure
_____ Sickle Cell
_____ Kidney Disease
_____ Mental Illness
_____ Rheumatism (arthritis)

PERSONAL HISTORY

Has your health been _____good_____fair_____poor. If not good explain _____

_____

What is your Blood Type? _____

List any medicines you take regularly or occassionally _____

(Thyroid, sedatives, headache pills, vitamins, iron, hormones, laxatives, insulin or allergy shots, birth control pills, etc.)

Do you use any of the following? _____ if yes, check appropriate one and explain.

_____ Hearing Aid
_____ Crutches
_____ Extremity or back
_____ Wheelchair
_____ Artificial Limb or Eye
_____ Eye Glasses
_____ Braces

_____

List any surgery or major illness: _____

INSURANCE — ALL INFORMATION MUST BE COMPLETED

Type	Company	Policy	Expiration Date
Accident and Hospitalization			
Auto			

Date _____ Student's Signature _____

An Equal Opportunity Employer / Facilities Accessible to the Disabled

PHYSICAL EXAMINATION (to be filled in by physician not more than 90 days before registration)

Height_____ Weight_____Pulse (sitting)_____ Resp._____ Blood Pressure (sitting)_____

CHECK EACH ITEM IN APPROPRIATE COLUMN:

Items	Normal	Abnormal	Additional Comments
Head, face, scalp, skin			
Neck, nodes, thyroid			
Eyes, ears, nose, & sinuses			
Mouth & teeth			
Pharynx & tonsils			
Lungs & chest			
Breasts			
Abdomen, hernia, scars			
Genitalia & rectum (if indicated in females)			
Extremities & feet			
Spine & musculoskeletal			
Reflexes			

Has this student any Chronic disease? _____ Explain_____

Is this student on any medication (insulin, dilantin, allergy injections, etc.)?_____

Give information as to medication name, dosage, etc._____

Is this student allergic to drugs, medicines, serum, etc.?_____Explain_____

_____

CHECK ALL PHYSICAL ACTIVITIES IN WHICH STUDENT MAY PARTICIPATE:

1.____ All contact sports and physical exercise
2. ____ All non-contact sports and physical exercise
3.____ Limited physical exercises
4. ____ No Physical exercises
5._____Gymnastics

If number 3 or 4 is recommended, please give explanation_____

_____

Physician's Name_____M.D.

Address_____
Number and street City, state, zip

Date of Examination:_____

IMMUNIZATION: Copy of immunization record including measles, rubella, mumps, polio, diphtheria and tetanus must accompany Medical History. This is a prerequisite for registration.

MEDICAL CONSENT FORM

In the event of a medical emergency or life-threatening situation and in consultation with a physician, I hereby grant the University official permission to authorize medical treatment for_____.

My permission is valid during his/her/my matriculation at Grambling State University unless revoked in writing. I will notify Grambling State University's Health Facility (318) 274-2351 of any major change in medical status during his/her/my tenure at the University.

_____ _____

Student's Signature Signature: Parent/Legal Guardian or Independent Student

*Failure to execute this form will relieve the University of any liability.
This medical consent form is valid as long as the above student is enrolled at Grambling State University.

Please return completed form to:

FOSTER-JOHNSON HEALTH CENTER
403 Main Street
P.O. Box 4251
Grambling, Louisiana 71245