

Grambling State University Foster-Johnson Health Center (318) 274-2351 (phone) Please submit forms via fax (318) 274-2481

MEDICAL HISTORY

Students are to complete the following form carefully. All information is confidential, and reviewed by Health Center Personnel only.

Student Information (Please				
Name:(Last)	(First)		(Middle)	
Address:	(0:1)	(5, 1)	(7° C 1)	
(Street) Telephone: ()	(City) 	(State) _ Email address:	(Zip Code)	
G-number:	Date of Birth:	Age:	Sex:	
Entering Semester/Year	Are you planning on living:	On Campus	Off Campus	
Emergency Contact Inform	ation			
Name:		Relationship:		
Home Phone: ()	Work Phone: ()	Cell Number: (_)
Family History				
·	ever had any of the following? (F Cancer High Blood Pressure Sickle Cell			
List any medical conditions you	Braces Hearing Aid		Eye Glas	
nsurance				
Туре	Company		Policy	Expiration Date
Accident and Hospitalization				
Automobile				
Automobile Medical Consent In the event of a medical emerge oractitioners and nurses, I hereby o my health and well-being; also granted. I understand that I am re	ency or life-threatening situation grant permission to authorize me o when necessary for executing a esponsible for personal expenses is enrolled at Grambling State U	dical treatment or othe such care, permission not provided by the st	er medical care that might for hospitalization at arudent insurance plan.	nt be deemed nec accredited hosp
(Signature of Student)	Date (Signatu	re of Parent/Legal Guard	dian, if required)	 Date