ANDREW COLLEGE HEALTH INFORMATION FORM

Full Name_____Date_____
PRINT LAST FIRST MIDDLE INTIAL
Home Address_____
STREET CITY STATE ZIP
Date of Birth_____Age_____Sex_____Race_____

Name of Parents or Guardian_____

Telephone # (Home) _____ (Work) _____ (Cell) _____

Name & Address of Family Physician_____

When was your last physical examination? _____

Purpose of Examination _____ *Routine Check Up* _____ *Illness/Injury*

Notes_____

1. Do you have a health problem? (Check where appropriate)
   _____*Asthma* _____*Diabetes* _____*Vision* _____ *Blood Disorder/Anemia* _____ *Injury* _____*Hepatitis*
   _____ *Allergies* _____ *Hernia* _____*Hearing* _____ *Seizures/Convulsions* _____*Heart* _____*Headaches*
   _____*Bone/Joint* _____*Urinary* _____*Skin* _____*Psychological* _____*Kidney* _____*Digestive*

   _____*Other*
   _____

2. Do you take medication? _____ Yes _____ No

3. Are you currently under the care of a medical professional? _____Yes _____No

4. If the answer to # 3 is yes, name and contact information of medical professional. _____

5. Prescriptions: _____
   Over the Counter Drugs_____
   _____ I am not currently taking any medications.

6. List any injuries/surgeries _____N/A

Injury/Surgery	*Date(s)*
_____	_____
_____	_____

7. List any allergic reactions to medications or injections: _____N/A _____

8. Is there additional information about your health that you think is important for us to know?
   Explain:_____

---

9. Do you know of any reason why you could not participate in an unlimited athletic program? ____YES___NO

10. If answer to #9 is yes, please explain: _____ ___ N/A

11. It is strongly recommended that all students have medical insurance either through their parents' policy or individually. Many physicians and hospitals now require either evidence of insurance or pre-payment as a condition for treatment.

INSURANCE CO._____POLICY NUMBER_____

To the best of my knowledge the above information is true and correct: _____
SIGNATURE DATE

Permission for Treatment In the event of serious illness or injury, or the need for major surgery, I understand an attempt will be made by a physician or Andrew College to contact the parent, guardian, or designated contact. If said physician or College is unable to communicate with any of the above listed individuals, the necessary treatment for the above student may be given. A parent or guardian must sign if the student is under 18 in order for medical treatment to be given. If statement is not signed, the hospital/doctor must first get permission from the parent/guardian before medical treatment is administered.

PARENT/GUARDIAN_____DATE_____

STUDENT _____DATE_____

Athletics If I chose to participate in Andrew College Athletics, I understand that a copy of the Health Information Form will be forwarded to the Athletic Trainer.

STUDENT _____DATE _____

Statement Regarding Meningococcal Disease (Meningitis) Immunization

In compliance with House Bill 52 of the Georgia General Assembly the following information, to take effect on January 1, 2004, is required for you to know:

(1) Meningococcal disease is a serious disease that can lead to death within only a few hours of onset; one in ten cases is fatal; and one in seven survivors of the disease is left with a severe disability, such as the loss of a limb, mental retardation, paralysis, deafness, or seizures;

(2) Meningococcal disease is contagious but a largely preventable infection of the spinal cord fluid and the fluid that surrounds the brain;

(3) Scientific evidence suggests that college students living in dormitory facilities are at a moderately increased risk of contracting meningococcal disease; and

(4) Immunization against meningococcal disease will decrease the risk of the disease.

Andrew College strongly recommends that all persons staying in a resident hall be immunized against meningococcal disease (meningitis).

I, _____, with signing this document, have read and understand the above statements regarding meningococcal disease (meningitis).

_____ Check here only **if you know you have been immunized** against meningococcal disease (meningitis).

Signature of Student _____
Date

Signature of Student's Legal Guardian if less than 18 years of age Date

Please Print Information and Return to Student Life