TUSKEGEE UNIVERSITY STUDENT HEALTH SERVICES
MEDICAL INFORMATION FORM

Please Read Carefully: This document is the property of Tuskegee University Student Health Center. Immunization information will not be released or sent to other Health Agencies and Educational Institutions. (*Please make a copy for your own records). Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause delays of your medical care.

COMPLETE ALL PAGES/PARTS 1, 2 and 3 as required, and return by June 30th.

Mail or Fax To:
Student Health Services
John A. Kenney Hall, Suite 71-235
Tuskegee University
Tuskegee, AL 36088
TEL: 334-727-8641 FAX: 334-724-4437

PART 1:

Name: ____ Social Security #: _____-_____-_____
Last First Middle Initial

Date of Birth: ____________ Gender: ___M ___ F ___Other Email Address: __________________

Home Address: ___________________________ City: ______________ State: _______ Zip: _______

Tel: Home____________________ Cell:____________________

Emergency Contacts:

1. Name _________________________ Tel:________________ Relationship_______________

2. Name _________________________ Tel: ________________ Relationship_______________

Semester entering school (Semester/Year): _________________________

Please check one of the following: _____Freshman _____Transfer ____Football____ Vet. Medicine

HEALTH INSURANCE (*Skip, If No Coverage)

Name of Health Insurance: ____________________ Contract #: ________Group #: _________

Name of Policy Holder: ______________________ Relationship: _______________

CONSENT FOR TREATMENT at Tuskegee University Student Health Services (*If under 18, co-signed by parent or legal guardian).

______________________________ ________________________________ ____________
Student Signature Parent or Legal Guardian Signature Date

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PART 2 -PHYSICAL EXAM

(TO BE COMPLETED BY MEDICAL PROVIDER)

Student's Full Name ________________________________ Date of Birth ________________

Date of Physical Exam (must be within the last 6 months): __________Height: _____Weight: _______

Blood Pressure: ______ Pulse: ______

For Medical Provider, please circle below as indicated:

General appearance	Normal	Abnormal
HEENT	Normal	Abnormal
Neck and thyroid	Normal	Abnormal
Heart	Normal	Abnormal
Lungs	Normal	Abnormal
Abdomen	Normal	Abnormal
Genitourinary	Normal	Abnormal
Skin	Normal	Abnormal
Neurological	Normal	Abnormal
Psychological	Normal	Abnormal

Summary of abnormalities (Attach documents, if indicated):

____

List ALL Allergies:

____

Is the student receiving medical care for a chronic condition or serious illness? YES NO

Do you feel that there are any mental or emotional issues that we should be aware of? YES NO

Do you have any concerns about the student participating in strenuous physical activity YES NO

Summary of clinical concerns and recommendations (Attach documents, if indicated):

____

PART 3 - IMMUNIZATION RECORD

REQUIRED Immunizations: Measles, Mumps and Rubella (MMR).

*Two doses of MMR OR evidence of positive titer is required for all students born after 1956.

Date of MMR #1: ____________ Date of MMR #2: ______________ OR Date of Positive Titer: ___________

Highly Recommended Vaccines:

Meningococcal Vaccine – All incoming students; 1 dose on or after age 16

Date of Meningococcal Vaccine: ________________________________

REQUIRED PPD (TB Skin Test) within the 12 months:

Date given: _____________ Date read: _____________ Results: _______________

If positive, attach Chest x-ray results: _______________

Health Care Provider's Signature: ____________________________ Date: ____________________

Print Health Care Provider's Name: ___________________________ Date: ____________________

Address: ____

____

Tel. No: ____

Fax #: ____