Health

Information Form

EMMANUEL COLLEGE

Franklin Springs, Georgia 30639-0129
800-860-8800 • 706-245-7226

This information is used by health services as an aid to providing necessary health care while you are a student. It must be completed and returned prior to registration for classes. This information will be held in the strictest confidence.

FOR TERM BEGINNING _____

SOCIAL SECURITY # _____

❑ MALE ❑ FEMALE DATE OF BIRTH _____

LAST NAME | FIRST | MIDDLE OR MAIDEN | MARITAL STATUS

HOME ADDRESS

CITY | STATE | ZIP | (_____) PHONE FOR NEAREST RELATIVE

NAME, RELATIONSHIP, & ADDRESS OF NEAREST RELATIVE

HEALTH INSURANCE INFORMATION

In order to be assured that students will receive quality health care should the need arise, it is **REQUIRED** that students be covered by hospitalization insurance while enrolled at Emmanuel College. This coverage may be in the form of a personal policy, family policy, or employer's policy under which the student is covered. If you have such coverage, please complete this section. If you do not have health insurance, please refer to the student costs section of the college catalog.

NAME OF INSURANCE COMPANY | PHONE NUMBER | NAME OF POLICY HOLDER

POLICY NUMBER | GROUP NUMBER AND EMPLOYER (if applicable)

FAMILY HISTORY

	Age	State of Health	Have any of your relatives ever had any of the following? (If yes, relationship)		
FATHER	_____	_____	TUBERCULOSIS	_____	_____
MOTHER	_____	_____	DIABETES	_____	_____
SIBLINGS	_____	_____	CANCER	_____	_____
	_____	_____	HEART DISEASE	_____	_____
	_____	_____	ARTHRITIS	_____	_____
	_____	_____	STOMACH DISEASE	_____	_____
	_____	_____	ASTHMA, HAY FEVER	_____	_____
	_____	_____	EPILEPSY, CONVULSIONS	_____	_____

PERSONAL HISTORY

Please check all that you have had and comment on all checked answers on an additional sheet.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

❑ Scarlet Fever
❑ Measles
❑ Arthritis
❑ German Measles
❑ Mumps
❑ Chicken Pox
❑ Gum/Tooth Trouble
❑ Sinusitis
❑ Eye trouble
❑ Glasses/Contacts
❑ Ear/Nose Trouble

❑ Throat Trouble
❑ Surgery–Year_____
❑ Appendectomy
❑ Tonsillectomy
❑ Other
❑ Diabetes
❑ Insomnia
❑ Frequent Anxiety
❑ Frequent Depression
❑ Worry or Nervousness
❑ Recurrent Headaches

❑ Recurrent Colds
❑ Head Injury
❑ Hay Fever, Asthma
❑ Tuberculosis
Allergic to:
❑ Penicillin
❑ Sulfonamides
❑ Serum
❑ Foods (attach list)
❑ Other
❑ Shortness of Breath

❑ Pain/Pressure in Chest
❑ Cancer
❑ Chronic Cough
❑ Palpitations (heart)
❑ High/Low Blood Pressure
❑ Rheumatic Fever or Heart Murmur
❑ Disease or Injury of Joints
❑ Trick Knee, Shoulder, etc.

❑ Back Problems
❑ Tumor/Cancer/Cyst
❑ Jaundice
❑ Stomach/Intestinal
❑ Gallbladder Trouble or Gallstones
❑ Heart Disease
❑ Recurrent Diarrhea
❑ Rupture, Hernia
❑ Recent Gain/Loss of Wt.
❑ Convulsions, Epilepsy

❑ Dizziness, Fainting
❑ Weakness, Paralysis
❑ Venereal Disease
❑ Albumin/Sugar
❑ Frequent Urination

FEMALES ONLY
❑ Irregular Period
❑ Severe Cramps
❑ Excessive Flow

OVER PLEASE

FAILURE TO ANSWER THE FOLLOWING QUESTIONS OR TO PROVIDE EXPLANATIONS WHERE NEEDED WILL RESULT IN AN INCOMPLETE FORM.

A. HAS YOUR PHYSICAL ACTIVITY BEEN RESTRICTED DURING THE PAST YEARS? ❑ YES ❑ NO **If yes, give reasons and duration.**

B. HAVE YOU HAD ANY ILLNESS OR BEEN HOSPITALIZED OTHER THAN ALREADY NOTED? ❑ YES ❑ NO **If yes, give details.**

C. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, OR OTHER PRACTITIONERS WITHIN THE PAST FIVE YEARS, OTHER THAN ROUTINE CHECK-UPS? ❑ YES ❑ NO **If yes, give details.**

D. DO YOU CONSIDER YOURSELF IN GOOD HEALTH? ❑ YES ❑ NO **If no, explain.**

E. IS THERE ANY REASON YOU CANNOT PARTICIPATE IN PHYSICAL EDUCATION CLASSES? ❑ YES ❑ NO **If yes, please attach explanation from physician or other medical authority.**

IMMUNIZATIONS

Please indicate below the dates of the immunizations listed. Those born after 1957 are strongly urged to have a second MMR. Also, all students are encouraged to be vaccinated for meningitis and hepatitis B.

1. TETANUS BOOSTER _____

2. ORAL POLIO VACCINE #1 _____ #2 _____ #3 _____ #4 _____

3. MMR (Measles, Mumps, Rubella): #1 _____ #2 _____

HEALTH CARE AUTHORIZATION

STUDENT: I understand that this form is a part of my official application to Emmanuel College. I agree to notify Health Services of any change that occurs in my physical or mental health, whether such change occurs prior to my registration or while I am a student at Emmanuel College. I give permission for diagnosis, therapeutic, and operative procedures to be used for my care as may be deemed necessary.

_____

SIGNATURE OF APPLICANT DATE

PARENT: Although parental signature is only required on this form if the applicant will be under age eighteen at the time of enrollment, it is strongly suggested that parental signature be included for all dependent students so that treatment can be expedited in the event of an emergency. In such case, an attempt will be made to contact the parent by telephone before any procedures are performed. I give permission for diagnosis, therapeutic, and operative procedures to be used for the care of my son, daughter, or ward as may be deemed necessary.

_____

SIGNATURE OF PARENT DATE

PLEASE RETURN THIS FORM TO:

Office of Admissions
Emmanuel College
P.O. Box 129
Franklin Springs, GA 30639-0129