SAVANNAH STATE UNIVERSITY

UNIVERSITY SYSTEM OF GEORGIA
HARRIS-MCDEW HEALTH CENTER
3219 COLLEGE STREET BOX 20448

SAVANNAH, GA 31404
PHONE: (912) 358-4122
FAX: (912) 358-3667

Student Medical History Questionnaire: # 915_____

The Harris-McDew Health Center is on the campus of the University and committed to providing quality primary health care. Each student should have a completed medical history form on file in the Student Health Center. Please fill out this form completely and return it to the Student Health Center before registration. Your medical history is confidential and will not be released to other agencies without your consent unless there is a medical emergency.

Part I is to be completed by the student or parent. Part II should be completed by a physician.

Name_____ Expected Enrollment Date: _____
Last First Mi

Home Address:_____
Street City State Zip Phone Number

Sav'h Address/Resident Hall:_____
Street Room # City State Zip Cell Number

Social Security Number: _____-_____-_____ Marital Status: ( ) Married ( ) Single ( ) Divorced

Sex: Male ( ) Female ( ) Birth Date_____ Age:_____ Race: _____

Health Insurance (Private, Public Assistance, Military)

Name of Insurance Company:_____ Policy # _____

Insurance Company_____ Phone: ( )_____
Street City State

Policy Holder: _____ Home Phone: ( )_____

Group Name: _____ Group Number: _____

****All students should be covered by some type of medical health insurance to cover care not provided at the SSU Student Health Center: Insurance information is available at the Student Health Center.****

PERSONS TO NOTIFY IN EMERGENCY

List below two relatives or other individuals who may be notified in case of an emergency.

1.Name_____ Relationship_____

Address_____ Telephone (_____)_____
City State Zip

2. Name_____ Relationship _____

Address_____ Telephone ( ) _____
City State Zip

REPORT OF STUDENT MEDICAL HISTORY

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

If you are under 18 years of age, you and your parent or guardian must sign below in the space designated. If you are 18 years or older, your signature alone will suffice.

I hereby authorize the physician and nurses of the Savannah State University Health Services to perform diagnostic and treatment procedures on the student named below, which may become necessary while enrolled at Savannah State University. I waive all claims to prior notification. In serious matters, the treating agency will attempt to notify the parents, guardians, or spouse.

SIGNATURES

Student _____ Date _____

Parent or Guardian _____ Date _____

Part II

To the Physician:

Savannah State University Health Center staff is convinced that a complete Health Examination by the family doctor before attending the university is valuable. Your knowledge of the student's background and medical history make it possible for you to give advice and recommendations that will help students while enrolled. For screening purposes we require a Urinalysis, CBC, and a Physical Exam. A chest x-ray should be done if indicated. Additional tests and treatments should be done when indicated. Give Immunizations against Measles, Diptheria, Mumps, and Polio within the period recommended by public health authorities and report on ***The Certificate of Immunization.*** Please inform us if this student is receiving or should receive any special treatment. Please advise the student on his or her need for a dental, visual exam. Special medical problems should be attended to before he or she leaves home. Thank you very much for your cooperation.

Name of Student _____ _____
LAST FIRST MIDDLE DATE OF EXAMINATION

Age:_____ Height:_____ Weight:_____ B/P:_____ Pulse:_____

C.B.C.: Hemoglobin _____ Red Cells: _____ White Cells: _____ Blood sugar:_____

Other positive test results:_____

Result of chest-x-ray if indicated:_____

Drug Allergies:_____

1. Please forward a copy of the Required SSU Immunization Form to the Admission Office.

2. Forward Medical History Form to the Student Health Center.

REPORT OF STUDENT MEDICAL HISTORY

Skin: Normal, Eruptions (Describe)_____
General Appearance: Strong, Vigorous, Delicate, Others_____
Eyes: Rt._____ Left: _____
Ears: Rt. _____ Left: _____
Nose and Sinuses: _____
Mouth: _____ Speech Defect? _____
Teeth: _____Caries_____Pyorrhea?_____Gingivitis?_____
Throat: _____
Neck: Lymph Node:_____ Thyroid: _____
Heart: Rhythm _____Murmur?_____ Enlargement?_____
Lungs:_____
Breasts:_____
Abdomen: _____
Skeletal System: Defects_____ Spine:_____ Feet:_____
Posture:_____ Reflexes:_____
Genitourinary: _____
Urinalysis: Results_____
Pelvic Exam/Include current Pap Smear Report:_____
_____
Has the applicant been diagnose with an emotional or mental illness?_____
If so, explain_____
Does the applicant have a chronic disability? No: ( ) Yes: ( ) DX:_____
Disabled Students should contact the OFFICE OF COUNSELING and DISABILITY – PO BOX 20521 – Phones (912) 356-2285 or 356-2202.
List routine medicines_____
Do you recommend that this student be exempted from any physical activities, please state reason:_____
_____
Remarks_____
Doctor's Signature_____Address_____
Date of Exam:_____ Phone ( )_____Fax ( )_____

Please return SSU Immunization form to the Office of Admissions. Mail or deliver this form when completed to:

Savannah State University
Harris-McDew Health Center
3219 College Street
Box 20448
Savannah, Georgia 31404
****Students should make a copy of their health form for their own record**** ***Revised 9/26/13***