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

TUSKEGEE UNIVERSITY STUDENT HEALTH SERVICES

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 em81.881 -2.ye:22E 1sA2.06 Tc 0219 c 9.6401sAy(Is)-.108h)9(erty)-5we -5w

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 #: _____