Health and Wellness Center
Office of Student Affairs
DIVISION OF STUDENT SUCCESS
Medical Record

You are encouraged to return this completed form BEFORE REGISTRATION or you may not be able to register for classes during SOAR/Registration sessions.

Last name: _______________________ **First:** ______________________ **MI:** ___ **Dillard Student ID #** ______________
Primary email address: ____ @ ________________________ . __________
Permanent Address: City __________________________ **State:** _____________________ **Zip code:** _________________
Birthdate: Month__________ **Date** ________ **Year** ______ **Citizenship: USA** _______ **Other (Specify)** ______________

MANDATORY
Emergency contact: Last name: ___________________________ **First:** _______ _____________ **Relationship:** __________
Address: City __________________________________ **State:** ____________ **Zip code:** ___________________________
Home: ( ) ________________________ **Work:** ( ) _____________________ **Cell:** ( ) _____________________

Health Insurance Company: ____ **Policy Number:** ______________________
(***Please attach a copy of the front and back of the insurance card to the back of this form***)

History of Surgery: Y___ N ___ (If yes, name of surgery and year): ____________________________________
____

List all *allergies* and *reactions* to the following if applicable:
Drugs: ____
Foods: ____
Environmental: ____

List ALL current medications and dosage of medication: (Prescribed and over the counter medications).
___________________________ ____________________________ ________________________________
___________________________ ____________________________ ________________________________

Have you ever had any of the following*: *(Check all that apply)

___ Alcohol Abuse
___ Anemia
___ Chronic cough
___ Convulsions/Seizure
___ Chronic headache/Migraine
___ Intestinal/stomach disorder
___ Kidney disease
___ Menstrual problems
___ Sleep disorders
___ Positive TB skin test
___ Chronic sinus infections
___ Drug abuse
___ Arthritis
___ Back problems
___ Eating disorders
___ Heart disease
___ Malaria
___ Mono
___ Orthopedic problems
___ Stroke
___ Tuberculosis (TB)
___ Chronic bladder/urinary infections
___ Depression
___ Asthma
___ Colitis
___ Hay fever
___ Head injury
___ Heart Murmur
___ Pneumonia
___Rheumatic fever
___ Spleen removed
___Thyroid disease
___ Tobacco use
___ Cancer
___ Diabetes
___ Hepatitis
___ Hernia
___Hemophilia
___ Polio
___ Mumps
___ Measles
___ Chicken pox

Brief history explaining any of the above items checked:
____
____

I certify that the Medical history I have provided is accurate and complete to the best of my knowledge.

____________________________________ Date: ________________________
(Student's signature)

____________________________________ Date: _________________________
(Parent or Guardian's signature)

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