



*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)

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Back problems | <input type="checkbox"/> Colitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions/Seizure | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chronic headache/Migraine | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Head injury | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Intestinal/stomach disorder | <input type="checkbox"/> Malaria | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mono | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Sleep disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Spleen removed | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Positive TB skin test | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Chronic sinus infections | <input type="checkbox"/> Chronic bladder/urinary infections | | |

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.

 (Student's signature)

Date: _____

 (Parent or Guardian's signature)

Date: _____

May 9, 2018