

To the Student: This form MUST be completed. Information you provide will be used as an aid to providing necessary care while you are a student. The form will not affect admission decisions but must be filled out completely and mailed to Student Health Services, North Georgia College & State University, Dahlonega, Georgia 30597. This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and written consent.

**NORTH GEORGIA COLLEGE & STATE UNIVERSITY – MEDICAL REPORT**

LIST THREE TELEPHONE NUMBERS TO CALL IN THE EVENT OF AN EMERGENCY:

Date of Expected Entry \_\_\_\_\_  
 Resident Student \_\_\_\_\_  
 Military Student \_\_\_\_\_  
 Commuting Student \_\_\_\_\_

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_

NAME \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (LAST) (FIRST) (MIDDLE) (SOCIAL SECURITY NO.)

HOME ADDRESS \_\_\_\_\_ HOME PHONE NO. (\_\_\_\_) \_\_\_\_\_

(CITY) (STATE) (ZIP CODE)

Date of exam \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

**SECTION A: DISEASE AND MEDICAL HISTORY (to be completed by applicant)**

Have you had or do you have:

YES / NO		YES / NO		YES / NO	
____/____	Rheumatic Fever	____/____	Stomach, Liver or Intestinal Disease	____/____	Allergies
____/____	Measles	____/____	Nervous Disorder	____/____	Migraine Headaches
____/____	Mumps	____/____	Kidney Disease	____/____	Arthritis
____/____	Meningitis	____/____	Diabetes	____/____	Pneumonia
____/____	Polio	____/____	Skin Disease	____/____	Heart Condition
____/____	Tuberculosis	____/____	Ear, Nose or Throat Problems	____/____	Irregular Heartbeat

Have you ever been hospitalized? \_\_\_\_\_ If "yes," when, where and why? \_\_\_\_\_

Have you ever received psychiatric/psychological treatment? \_\_\_\_\_ If "yes," when, where and why? \_\_\_\_\_

Are you taking medication for this treatment? \_\_\_\_\_ If "yes," list medication \_\_\_\_\_

Do you have epilepsy? \_\_\_\_\_ If "yes," list date of your last seizure \_\_\_\_\_ List medications for this \_\_\_\_\_

Do you have asthma? \_\_\_\_\_ If "yes," list date of your last attack \_\_\_\_\_ List medications for this \_\_\_\_\_

Have you had any fractured bones? If "yes," please explain \_\_\_\_\_

Do you have any joint problems, such as: shoulders, elbows, wrists, hips, knees, feet? \_\_\_\_\_ If "yes," please explain \_\_\_\_\_

Do you have migraine headaches? \_\_\_\_\_ If "yes," list date of last headache \_\_\_\_\_ List medications for this \_\_\_\_\_

Have you had any past surgeries? \_\_\_\_\_ If "yes," please explain \_\_\_\_\_

Do you have any history of injury to neck? \_\_\_\_\_ Chest? \_\_\_\_\_ Back? \_\_\_\_\_ Head? \_\_\_\_\_ If "yes," please explain \_\_\_\_\_

Are you taking any medication? \_\_\_\_\_ If "yes," please explain \_\_\_\_\_

Are you allergic to bee stings? \_\_\_\_\_ If "yes," do you use an epi-pen? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ If "yes," please list \_\_\_\_\_

Do you have any physical or mental limitations that you are aware of? \_\_\_\_\_ If "yes," please list \_\_\_\_\_

**SECTION B: PHYSICAL EXAMINATION (To be completed by Physician)  
Mandatory for all Military Students (Optional for Others)**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

List any problems or observations on any of the following areas:

Throat & Tonsils	Lungs
Heart	Genito-Urinary System
Abdomen (pains, scars, masses)	Hemorrhoids
Hernia	Congenital Abnormalities
Psychiatric History (if any)	Others

Remarks continued: \_\_\_\_\_

I have examined the person whose name appears on the reverse side of this form pending his/her enrollment at North Georgia College & State University, and find him/her:

- ( ) Qualified for unrestricted exercise (may include push-ups, sit-ups and running)
- ( ) Qualified for restricted exercise only (explain/specify below)
- ( ) Qualified for absolutely no physical exercise (explain below)

List any conditions that would limit this student's participation in physical activities (i.e., recent surgery or illness, chronic health problems such as tick knees or asthma, etc.) or if restricted exercise is noted above, a letter of limitations and time limit must be attached to this form by examining M.D. \_\_\_\_\_

\_\_\_\_\_  
EXAMINING PHYSICIAN (PLEASE PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF EXAMINING PHYSICIAN

(\_\_\_\_\_)\_\_\_\_\_  
TELEPHONE NO.

\_\_\_\_\_  
ADDRESS

**SECTION C: WAIVER/RELEASE  
STUDENT WAIVER**

(For Participants in the Military)

I understand that the military program at North Georgia College & State University is physically strenuous and release North Georgia College & State University, its employees and staff from any liability in case of illness or injury sustained in training.

\_\_\_\_\_  
STUDENT'S NAME (PLEASE PRINT)

\_\_\_\_\_  
STUDENT'S SIGNATURE

**ALL STUDENT INFORMATION RELEASE**

I hereby authorize the release of medical information to officials of North Georgia College & State University from any doctor or hospital that I may utilize in case of illness or injury. I further authorize the physicians of the Student Health Services, their agents or consultants, to perform diagnostic and treatment procedures which in their judgment may become necessary while I am in attendance at North Georgia College & State University.

\_\_\_\_\_  
STUDENT'S NAME (PLEASE PRINT)

\_\_\_\_\_  
STUDENT'S SIGNATURE

**PARENTAL RELEASE**

(Students Under 18 Years of Age)

As the parent, guardian, or next of kin of \_\_\_\_\_, I give my permission for him/her to receive necessary, routine medical attention while enrolled at NGCSU.  
(STUDENT'S NAME)

\_\_\_\_\_  
PARENT/GUARDIAN (PLEASE PRINT)

\_\_\_\_\_  
RELATIONSHIP

(\_\_\_\_\_)\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
PARENT'S/GUARDIAN'S SIGNATURE

Students covered under Parent's Health Insurance should attach a copy of their insurance card to expedite treatment in the event off-campus referral is required.