



Student Health History

(Please print or type)

All traditional students must have completed health form on file.

Return **immediately** to the: Dean of Students Office
 Averett University
 420 West Main Street
 Danville, VA 24541

Student's Full Name _____
(Last) (First) (Middle)

Social Security Number _____ Birth date _____

Check one of the following:

- New Averett University Student Returning Averett University Student

If you plan to participate in intramural activities, a physical examination is recommended.

In case of Emergency, notify: (Required to list two people)

Name _____	Name _____
Address _____	Address _____
City/State _____	City/State _____
Telephone (home) _____	Telephone (home) _____
Telephone (work) _____	Telephone (work) _____
Relationship _____	Relationship _____

Update Of Illnesses: (Please check all that you have had in the last year)

Allergies	Hypertension (High Blood Pressure)	Seizure Disorder
Asthma	Mental Disorder	Tuberculosis
Congenital Heart Defects	Poliomyelitis	Frequent Urinary Infections
Diabetes	Rheumatic Fever	OTHER:
Hepatitis	Rubella (German Measles)	

- Are you receiving any regular treatment or taking medication? _____ If yes, please specify name of drugs, including insulin, prophylactic penicillin, anti-convulsive drugs, etc. Please attach a copy of all prescriptions to this health form.

- Specify all allergies (drug, food, environmental) and type of reaction:

- Describe any physical limitations (i.e. hearing, vision [including contact lenses], and mobility):

- Describe any surgery you have had and give dates:

Immunizations:

MMR (Measles, Mumps, and Rubella)	Date Completed: _____
Tetanus Toxoid (Must be within last 10 years)	Date Completed: _____
TB (Tuberculosis) Skin Test	Date Completed: _____
or Chest X-Ray	Date Completed: _____
Meningitis Vaccination (Required by all incoming students)	Date Completed: _____

Verification of Immunization Record (Not required for returning students if there have been no changes):

Signature of Certified Medical Practitioner

Name of Medical Facility

Facility Telephone Number

**Please attach a legible copy of the insurance card on the appropriate box using clear tape.
(DO NOT STAPLE)**

FRONT OF INSURANCE CARD

BACK OF INSURANCE CARD

I am planning to purchase insurance through the university. I will provide a copy of the front & back of my card when I receive it.

I hereby authorize any licensed physician or hospital that has treated or attended the above claimant to furnish the insurance company or its representatives any information requested for completion of a claim. A Photostat of this authorization shall be considered as effective and valid as the original.

I verify that the information on this form is complete and accurate. Information may be released to those persons responsible for the health and welfare of the student body. Should an accident or illness occur after the completion of this form, I would furnish pertinent information to the Dean of Students.

Signature of Parent-Guardian _____ Date _____

Signature of Student _____ Date _____