

**Averett University**

**Update to Health Records**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex \_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Current College Year: Sophomore\_\_\_\_\_ Junior \_\_\_\_ Senior \_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip Code)

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance**

Do you have private Health insurance: Yes \_\_\_\_\_ No \_\_\_\_\_\_

Do you have School Health Insurance: Yes \_\_\_\_ No \_\_\_\_\_\_

**\*\* Please attach a copy of your insurance card\*\***

*Emergency Contact Information*

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Students Must Answer All Questions**

**Personal Medical History**

|  |  |  |
| --- | --- | --- |
| Abnormal Bruising No\_\_\_ Yes\_\_\_ | ADD/ADHD No\_\_\_ Yes\_\_\_ | Anemia No\_\_\_ Yes\_\_\_ |
| Asthma/Bronchitis No\_\_\_ Yes\_\_\_ | Cancer No\_\_\_ Yes\_\_\_ | Chickenpox No\_\_\_ Yes\_\_\_ |
| Depression/ No\_\_\_ Yes\_\_\_  Anxiety | Diabetes No\_\_\_ Yes\_\_\_ | Eating Disorder No\_\_\_ Yes\_\_\_ |
| Epilepsy/Seizures No\_\_\_ Yes\_\_\_ | Fainting No\_\_\_ Yes\_\_\_  Spells/Dizzy | Fatigue No\_\_\_ Yes\_\_\_ |
| Frequent Cold/ No\_\_\_ Yes\_\_\_  Sinus Infections | Hay Fever/ No\_\_\_ Yes\_\_\_  Seasonal Allergies | Head Injury/ No\_\_\_ Yes\_\_\_  Concussion |
| Hearing No\_\_\_ Yes\_\_\_  Problems | Heart Disease/ No\_\_\_ Yes\_\_\_  Heart Murmur | Hepatitis No\_\_\_ Yes\_\_\_ |
| Hypertension No\_\_\_ Yes\_\_\_ | Irritable Bowel/ No\_\_\_ Yes\_\_\_  Spastic Colon | Menstrual No\_\_\_ Yes\_\_\_  Problems |
| Mental No\_\_\_ Yes\_\_\_  Health Issues | Migraines/ No\_\_\_ Yes\_\_\_  Chronic Headaches | Mono No\_\_\_ Yes\_\_\_ |
| Obesity No\_\_\_ Yes\_\_\_ | Pelvic Infections/ No\_\_\_ Yes\_\_\_  STD’s | Pneumonia No\_\_\_ Yes\_\_\_ |
| Recurrent No\_\_\_ Yes\_\_\_  Bladder/Kidney  Problems | Scoliosis No\_\_\_ Yes\_\_\_ | Sickle-Cell No\_\_\_ Yes\_\_\_  Disease |
| Smoker No\_\_\_ Yes\_\_\_ | Substance Abuse/ No\_\_\_ Yes\_\_\_  Alcohol Abuse | Suicidal No\_\_\_ Yes\_\_\_  Thoughts |
| Thyroid No\_\_\_ Yes\_\_\_  Disease | Tuberculosis/ No\_\_\_ Yes\_\_\_  Lung Disease |

Have you ever had the following?

Details of above, if necessary:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any illness/condition, not listed above, for which you are being treated:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete the following:**

List dates of any serious injuries, hospitalizations, illnesses or operations.

Circle **none** or, if applicable, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any emotional disturbances or adjustment problems.

Circle **none** or, if applicable, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you are currently taking, including dosage and scheduled administration, including over-the-counter.

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | When Taken (daily, weekly, monthly) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you want/need a lockbox for your medication? Yes\_\_\_ No\_\_\_

Are you allergic to any medications? Yes\_\_\_ No\_\_\_ Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? Yes\_\_\_ No\_\_\_

Please specify your allergies below (medications, food, other):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission for Treatment**

Averett University has my permission to perform or authorize routine medical care by a licensed health care professional, including assessment and treatment by Director of Health Services RN, check-ups, immunizations, and/or treatment for minor injuries and illness, and to make referrals to area specialists and medical services. Under certain circumstances, the student may be transported to an area hospital for diagnosis and treatment.

This form must be signed by the student. If the student is a minor (under 18 years of age), this form must also be signed by the parent or legal guardian so that appropriate diagnosis and treatment may be promptly carried out. No major health services will be performed, except in an emergency, without a parent or legal guardian being contacted and fully informed if the student is a minor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian (if student is a minor) Relationship Date

**Please return forms directly to Tammi Devlin, Director of Health Services at:**

Health Services Clinic

Student Success center

420 W. Main St

Danville, VA 24541

Phone# 434-791-5718

health@averett.edu