Health History Record
Louisiana College Health Services
1140 College Drive, Box 106
Pineville, LA 71359
318-487-7750
cmartin@lacollege.edu

Date ___________________________________

Semester of enrollment:
ξ Fall ξ Spring ξ Summer Year:__________

Major _________________________________

Class location:
ξ on campus
ξ on line only
ξ off campus, in Pineville

CONFIDENTIAL : Must be completed and returned before registering for classes **PLEASE PRINT**

CONTACT INFORMATION

Name ____**M/F__**
Last First Middle Maiden Nickname Gender

Address ____
Street/P.O. Box City/Town State Zip Code

Date of Birth __________________________ Age ____________ Home Phone (______)____________________ Cell Phone (______)______________________

Persons to be notified in an emergency: Student e-mail address____

Name ____ Phone (______)__________________________ Relationship _________________________________

Name ____ Phone (______)__________________________ Relationship _________________________________

HEALTH INSURANCE INFORMATION

SUBMIT COPY OF BOTH SIDES OF INSURANCE CARD

Name of Ins. Co. ____ Group # ______________________________ Policy # ___________________________________

ALLERGIES

To Medication ____ Food ____

Bee Sting ____ Other ____

Are you now taking allergy vaccine? ξ **No** ξ **Yes** – Please have your physician send pertinent information to us so that we can continue to give your allergy injections.

MEDICATIONS

Current medications (include dosage) ____

HISTORY OF ILLNESS

Have you ever or do you now have any of the following? Check all that apply.

	Alcoholism or chemical dependency		Heart disease		Painful menstruation
	Anemia or other blood disease		High blood pressure		Rheumatic fever
	Asthma		Hepatitis		Skin disease
	Bone or joint disease		Kidney disease		Stomach trouble, intestinal disease, or ulcer
	Cancer		Major trauma, multiple injuries		Suicide attempt
	Chickenpox		Migraine headaches		Tonsillitis
	Convulsions		Meningitis		Have you ever had a BLOOD transfusion?
	Diabetes		Mononucleosis		Other serious illnesses?
	Drug or alcohol overdose		Psychiatric treatment		Other medical problems?
	Ear, nose, or throat disease		Psychological problems		Handicapping conditions
	Eating disorder		Psychological counseling		Hospitalization
	Eye disease				

Explanation of all checked answers ____

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PERSONAL HISTORY Please check all that apply.

	I have physical handicaps or disabilities. Please explain.____________________
	I have special health requirements? Please specify.____________________
	I have consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 years other than for routine checkups. Please explain. ____________________
	I have been diagnosed and/or treated for an eating disorder (Anorexia nervosa, bulimia, or other) and have been/am being treated for it. Please explain. ____________________
	I have dietary restrictions. Please explain. ____________________
	I have been involved in counseling or psychiatric therapy for a nervous condition, personality disorder, family situation, or emotional problem. Give details. ____________________
	I have been treated for chemical dependency. Type ____________________ Duration of treatment program. ____________________

AUTHORIZATION FOR MEDICAL CARE AND RELEASE OF INFORMATION

IN ORDER TO PROMOTE ACCESS TO MEDICAL CARE FOR STUDENTS WITH MEDICAL ILLNESS, WHETHER PHYSICAL OR EMOTIONAL, EACH STUDENT EIGHTEEN (18) YEARS OF AGE (OR OVER) OR THE CUSTODIAL PARENT/GUARDIAN OF EACH STUDENT UNDER EIGHTEEN (18) YEARS OF AGE **AGREES** AS FOLLOWS:

I do hereby give and grant unto the Louisiana College school physicians and nurses my consent to perform routine medical care through Louisiana College Health Services and necessary emergency care procedures and to use their own judgment in securing medical aid and/or emergency transportation. I understand that I am financially responsible for any and all medical expenses incurred.

I further hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care as may be required on an emergency basis, in the event that I should be stricken ill while under the supervision of Louisiana college personnel. This permission includes admission to a hospital, emergency surgery, administration of medications, therapeutic procedures, etc., as deemed necessary by the attending physician.

I hereby authorize any physician or practitioner who has observed (student's name) ____________________ for diagnosis or treatment for any disease or ailment, and any hospital or clinic where I/she/he have or has been a patient for such diagnosis, treatment, disease, or ailment, to give full particulars thereof, upon request, to the Louisiana College Dean of Students.

If I participate in intercollegiate athletics, I give my permission for a copy of this health history and other pertinent health information to be given as needed for the treatment of illness to the Athletic Director, Coach, or Athletic Trainer.

I give my permission to Louisiana College Health Services to inform the Dean of Students, Student Counselor, and/or Residence Life Staff of pertinent health or emotional problems so my health may be maintained in an appropriate manner. I give my permission to the Health Services Staff for a referral for student counseling services as deemed appropriate by the college physician.

A Photostat of this authorization shall be valid as the original and any photostat and the original shall expire at the date the student graduates, or otherwise permanently ceases to be a student at Louisiana College.

SIGNATURES

STUDENT ____________________ **DATE** __________

All students must sign even if under 18 years of age

PARENT/GUARDIAN ____________________**DATE** __________

Required for Student under 18 years of age

PLEASE BE SURE TO READ AND SIGN THE ABOVE AUTHORIZATION

Revised March 2011