STUDENT MEDICAL HISTORY RECORD
(Confidential)

OFFICE USE ONLY
Comp._____
Temp. _____
HLD_____
Inc._____

Mail, Fax or Email to
TROY UNIVERSITY
Student Health Services
Troy, Alabama 36082
Phone (334) 670-3452
Fax (334) 670-3853
hcenter@troy.edu

This record must be filed with Student Health Services prior to registration.

Name_____ SS/ID No._____
Last First Middle

Permanent Home Address _____
Street City State Zip

Date of Birth_____ Sex_____ Phone_____ Cell Phone_____

Person to be notified in an emergency_____
Name

_____
Relationship Telephone Number (Home) (Work)

All students should carry Health Insurance. Please attach copy of front & back of insurance card.

Insurance Company _____ Name on card_____

Contract/Policy # _____ Group #_____

Personal Physician _____
Name Address Telephone Number

Troy University requires all students born after 1956 to submit official documentation of two (2) measles (rubeola) vaccinations.

REQUIRED VACCINATIONS. A copy of an official document may be attached.

		Date	Official Signature or stamp	Circle One
Measles:	#1	_____	_____	ME MR MMR
Measles:	#2	_____	_____	ME MR MMR

Troy University requires all students incoming Freshmen and transfer student to submit official documentation of TB skin testing within 12 months.

Tuberculin Skin Test Date given_____ Date read_____ Results_____ MM_____

_____**Official Signature or Stamp**

Chest X-ray and treatment must be submitted for positive skin tests.

Chest X-ray Date_____ Results_____

Recommended Treatment_____

_____**Official Signature or Stamp**

(over)

Past History

Check each item. Briefly comment on "yes" responses.

	Comment	Yes	No		Comment	Yes	No
*Allergy				HIV infection			
Anemia or other blood Disease				Kidney disease			
Anorexia				Meningitis			
Appendicitis, acute or chronic				Mononucleosis			
Arthritis				Nervous or mental disorder			
Asthma				Pneumonia			
Back Problems				Rheumatic fever			
Binge eating				Scarlet fever			
Bronchitis				Sexually transmitted infection			
Cancer				Sinus disease			
Chickenpox				Stomach problems or gastic reflux			
Diabetes				Thyroid trouble			
Epilepsy or seizure disorder				Tuberculosis			
Heart disease				Ulcer, stomach or duodenal			
Head aches				Vertigo (dizziness) or fainting spells			
Hepatitis							

Other diseases or conditions_____

Severe injuries_____

Surgical procedures _____

Current meds_____

MEDICAL CONSENT

I understand that I am responsible for my own physical and mental health, and for informing staff of any need for treatment.

I hereby affirm that all information supplied is complete and accurate to the best of my knowledge. I understand that withholding information requested or giving false information could be cause for dismissal. I hereby grant permission to the Troy University Student Health Service to render medical care that in their judgement is deemed advisable; to make necessary referrals; to release medical information necessary for appropriate care and treatment, and to authorize hospitalization when recommended in the event of illness or accident for_____
Print Name

Parents, guardians, or next of kin will be promptly notified in the event of serious illness or accident, except when delay by such communication would endanger life. I understand that Troy University cannot be responsible for chronic illnesses which are a part of the medical history of the student.

Signed_____ Date_____
*Signature of Applicant

Signed_____ Date_____
*Signature of Minor's Parent or Guardian

*A minor is a person under 19 years of age.