

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

TROY UNIVERSITY™

STUDENT MEDICAL HISTORY RECORD (Confidential)

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

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) MMR vaccines (measles, mumps, rubella).

A copy of an official document may be attached or signed below by your physician/nurse.

	Date	Official Signature or stamp
MMR: #1	_____	_____
MMR: #2	_____	_____

Troy University requires all students incoming Freshmen and transfer student to submit official documentation of either aTB skin testing or QB gold lab within 12 months or chest x-ray within 2 years. You may also have the portion below completed by your physician.

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 _____ Treatment Yes No

_____ Official Signature or Stamp

(over)

Name _____

Student ID _____

Past History

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

	Comment	Yes	No		Comment	Yes	No
ADHD				Hepatitis			
Anemia or other blood Disease				HIV infection			
Eating disorder				Kidney disease			
Appendicitis, acute or chronic				Meningitis			
Arthritis				Mononucleosis			
Asthma				Nervous or mental disorder			
Back pain/scoliosis				Pneumonia			
Cancer				Sexually transmitted infection			
Diabetes				Stomach problems or gastric reflux			
Epilepsy or seizure disorder				Thyroid trouble			
Heart disease				Tuberculosis			
Headaches				Vertigo (dizziness) or fainting spells			

Other diseases or conditions _____

Surgical procedures _____

Current meds _____

- 1. Have you ever been diagnosed and/or treated for depression, anxiety, or any other emotional disorder? Yes No
- 2. Have you ever talked to a psychiatrist, therapist, or counselor about an emotional problem? Yes No
- 3. Have you ever felt you needed help with your emotional problems, or had people tell you that you should get help with an emotional problem? Yes No
- 4. Have you ever attempted or had thoughts of suicide? Yes No

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 Troy University Student Health Services to render medical care that in their judgment 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.