

Tennessee Tech University

Student Health Form

GENERAL INFORMATION

Name _____ Birthdate ____/____/_____
Home Address _____ Phone Number (____) ____ - ____
number & street, P.O. box, or apt. # city state zip
Gender Male Female Student "T" Number _____ Marital Status S M D W
Emergency Contact Information: Name _____ Phone Number (____) ____ - ____
Family Physician: Name _____ Phone Number (____) ____ - ____

PAST MEDICAL HISTORY

Have you had any of the following conditions or related conditions? If "yes," please describe. List frequency and severity, medications or surgeries.

Respiratory System: hay fever, asthma, tuberculosis, sinus problems? Yes No _____
Cardiovascular: palpitations, high/low blood pressure, chest pain, heart murmur, heart disease? Yes No _____
Blood Diseases Disorders: anemia, bleeding tendencies? Yes No _____
Muscle-Skeletal: "trick" knee, back problems, broken bones, recurrent sprains/tendonitis, deformities, arthritis? Yes No _____
Endocrine: thyroid, diabetes, adrenal? Yes No _____
Gastro-intestinal: ulcer, gallbladder, diarrhea, constipation? Yes No _____
Genitourinary: menstrual problem, kidney/bladder problems, prostatitis, vaginal infections? Yes No _____
Neurological: seizures, hearing problems, head injury with unconsciousness? Yes No _____
Psychological: anxiety, depression, other emotional disorders? Yes No _____
Infections: rheumatic fever, malaria, hepatitis? Yes No _____
Surgeries: tonsillectomy, appendectomy, hernia repair, other? Yes No _____
Tumor/cyst/cancer? Yes No _____

CURRENT MEDICAL HISTORY

Allergies: medicines, bee stings, other? Yes No If "yes," please list: _____
Are you currently taking any prescribed drugs or medical treatment (including birth control pills)? Yes No
Do you know any reasons why you should not participate in normal physical exercise? Yes No
Do you have any questions regarding your health or other matters you'd like to discuss with the Health Services Staff? Yes No

IMMUNIZATION REQUIRED (requires signature or stamp from health care provider below)

Vaccines	Dates	Signature
MMR (measles, mumps, rubella) (proof of two)	1. _____	_____
	2. _____	_____

IMMUNIZATION RECOMMENDED (requires signature or stamp from health care provider below)

Tetanus (within past 10 years) _____

Meningitis _____
Hepatitis B
1. _____
2. _____
3. _____

TB Skin Test Date given: _____ Results _____

PERMISSION FOR TREATMENT AT TTU STUDENT HEALTH SERVICES

(if under 18, co-signed by parent or guardian)

Student signature Date Parent or guardian signature Date

Please return to Tennessee Tech University, Student Health Services, Box 5096, Cookeville, TN 38505-0001, fax 931-372-3848