TTU TENNESSEE TECH UNIVERSITY

Student Health Form

GENERAL INFORMATION

Name ______________________________ Birth Date ____/____/____

Home Address ______________________________ Phone Number (____) ________

Number & Street, P.O. Box or Apt. # City State Zip

Gender: ___Male ___Female T# ______________________________ 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 the frequency and severity, medications or surgeries.

_____ Yes _____ No | 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? __________

CURRENT MEDICAL HISTORY

_____ Yes _____ No | Allergies: medicines, bee stings, other? If "yes," please list: __________

_____ Yes _____ No | 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?

IMMUNIZATION REQUIRED (Requires signature or stamp from health care provider below or official document attached)

Vaccines	Dates		Signature
MMR (measles, mumps, rubella)	1. ________	2. ________	________
Varicella (chicken pox)	1. ________	2. ________	________

Or documentation of disease by medical personnel. __________

TB Skin Test Date: Results:

IMMUNIZATIONS RECOMMENDED (Requires signature or stamp from health care provider below or official document attached)

Tetanus (within past 10 years)	________	________
Meningitis	________	________
Hepatitis B	________	________
	________	________
	________	________

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, or fax to (931) 372-3848.