UNIVERSITY of MONTEVALLO

Student's Medical History

This medical history form is required of all NEW students. The completed form must be returned to Student Health Services before the first day of classes. All information is considered confidential.

To Be Completed By Student

FULL NAME: _____

STUDENT ID (M#): _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone/Cell Number: _____

Parent/Guardian: _____

Address: _____

Phone/Cell Number: _____

ALSO REQUIRED (Attach to this form):

1. **Tuberculosis (TB) Risk Questionnaire**
   If you are determined to be at risk from the questionnaire, a TB skin test will be required.
2. **Proof of #2 MMR vaccinations**
   If born in or after 1957: submit a **COPY** of your shot record ("blue form"). If record not available, submit results of a rubeola titer.

START DATE AT UM:

Year: _____

☐ Fall Term ☐ Spring Term ☐ May Term
☐ Summer I (June) ☐ Summer II (July)

OTHER INFORMATION:

Insurance Carrier: _____

Policy Number: _____

Family Physician: _____

Address: _____

Physician's Office Phone: _____

List other Physicians on back of form, if applicable.

STRONGLY RECOMMENDED VACCINES:

Hepatitis B; Meningitis; Td/Tdap
Varicella (Chicken Pox); Flu (seasonal)

INTERNATIONAL STUDENTS ONLY:

Please use the *International Medical Form:*
http://www.montevallo.edu/admissions/international-admissions/requirements/

STUDENT AUTHORIZATION:

- I hereby affirm that all information supplied is complete and accurate to the best of my knowledge.
- I understand that I am responsible for my own physical and mental health, and for informing staff of any need for treatment. I understand that the University of Montevallo is not responsible for chronic illnesses which are a part of the medical history of the student.
- I hereby grant permission to 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, including any necessary transportation of student for such care. 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 hereby assume responsibility for any costs for medical care beyond that provided by Student Health Services or that which is covered by the semester health fee.

Student Signature: _____ **Date:** _____

Parent/Guardian signature, if student under 18 years. Must have signature before services can be rendered.

*****PLEASE SUBMIT ALL HEALTH FORMS TO STUDENT HEALTH SERVICES (see page 2 for instructions)*****

Student's Medical History

FULL NAME: _____ *STUDENT ID (M#):* _____

STUDENT MEDICAL HISTORY

Circle if you have or have had any of the following:

Anemia	**Headaches**	**Seizures**	**Diabetes**
Blood disorder	**Depression**	**Assistive device**	**Thyroid disorder**
Asthma	**Anxiety**	**Stomach issues**	**Kidney/Urinary issue**
Allergies	**Mental illness**	**Heart condition**	**Hepatitis**
Sinus issues	**ADD/ADHD**	**High Blood Pressure**	**Tuberculosis**

OTHER PERTINENT HEALTH INFORMATION:
(including names and phone numbers of other physicians not listed on front)

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

MEDICATION ALLERGIES:

_____

_____

_____

Student Signature: _____ **Date:** _____

Parent/Guardian if student under 18 years. Must have signature before Health Services can be rendered.

PLEASE SUBMIT ALL HEALTH FORMS TO STUDENT HEALTH SERVICES

In Person: East Main Hall, during normal UM business hours.
US Mail: UM Student Health Services, Station 6275, Montevallo, AL 35115
Email: jadkins@montevallo.edu **Fax:** 205-665-8180