UNION UNIVERSITY

# Employee Health Form

Full Name _____ Gender: M _____ F _____
First Middle Last

Home Address _____
Street City State Zip Code

Phone (____) _____ SSN _____ Birth Date _____

Name of Spouse_____ Phone (____) _____

## Health Insurance Information

Name of Insurance Co. _____

Address of Insurance Co. _____

Subscriber's Name _____

Policy/ID No. _____ Group No. _____ Plan No. (If applicable) _____

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Current Medication (Dosage & Frequency):
_____

_____

Allergies (Medications, Foods, Substances, etc.) _____
_____

Current Health Problems and Past Health History: Please complete Health History Form on the back and sign area r/t release of health information.

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## Treatment Consent

In case of serious illness or accident, I give Union University or its representative(s) permission to secure medical and/or surgical care to include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a condition requiring minor care, I give my permission for treatment to the college physician or his staff.

All statements in this medical record are true to the best of my knowledge and belief. Should any change in my health status occur I understand that Student Health Services should be notified in writing.

**Employee Signature**: **Date:**

_____

## Union University Health History

### Employee Health History

Please check conditions below which pertain to your current or past medical history. Utilize the space provided to explain those areas identified.

| | | | |
|---|---|---|---|
| ( ) AIDS | ( ) Chemical Dependency | ( ) High Cholesterol | ( ) Prostrate Problems |
| ( ) Alcoholism | ( )Chicken Pox | ( ) Bladder Problems | ( )Psychiatric Care or Problems |
| ( ) Anemia | ( ) Diabetes | ( ) Kidney Disease | ( ) Rheumatic Fever |
| ( ) Anorexia | ( ) Emphysema | ( ) Liver Disease | ( ) Scarlet Fever |
| ( ) Appendicitis | ( ) Epilepsy | ( ) Measles | ( ) Stroke |
| ( ) Arthritis | ( ) Glaucoma or Cataracts | ( )Migraine Headaches | ( ) Thyroid Problems |
| ( ) Asthma | ( ) Goiter | ( ) Mononucleosis | ( ) Tonsillitis |
| ( ) Bleeding Disorders | ( ) Gout | ( ) Multiple Sclerosis | ( ) Tuberculosis |
| ( ) Breast Lumps | ( ) Heart Disease | ( )Mumps | ( ) Stomach Ulcers |
| ( ) Bronchitis | ( ) Hepatitis | ( ) Pneumonia | ( ) Polio |
| ( ) Cancer | ( ) Hernia | ( ) Blood Pressure Problems | ( ) Sickle Cell Anemia |
| ( ) Fractures | ( ) Major Surgery | ( )Back Problems | ( ) Anxiety |
| ( ) Depression | ( ) Bulemia | ( ) Menstration Problems | ( ) Veneral Disease |

**Explanation of Identified Conditions:**

_____

_____

_____

**Other Medical Problems:**

_____

_____

_____

### Consent for Release of Information

In order to provide continued and appropriate medical care, I give Union University or its representative(s) permission to release personal health information to health care professionals/medical facilities by means of: E-mail, FAX, phone, voice mail or answering machine.

Signature: _____ Date:_____