BRESCIA UNIVERSITY

Health History Consent and Release Form

Brescia University maintains health records on all students in order to help medical professionals facilitate proper health care in the event that it is needed. It is very helpful to have background medical history information and immunization records on new students. To assist us, we ask all new students to complete a Health History Form/Immunization records. The completed form as well as the Consent and Release form below, should be returned with your Housing Application/Contract.

- The Health History Form asks for general background information. We ask for medical history information such as allergies, daily medications, ongoing chronic illnesses, etc. This information assists emergency personnel in providing care.
- We also ask for an immunization record. It is important to verify that new students have received the usual childhood and routine immunizations. There is a place for this on the Health History Form or a copy of the records may be attached. A copy of the actual immunization records from your usual health care provider is ideal.

CONSENT AND RELEASE

I certify that I understand the contents of this form, and that my signature represents a free and voluntary act of consent thereto on behalf of the student named below. I further certify that I expect my specific information regarding service from Brescia University will not be released with out the express written consent of the Student unless disclosure is mandated by law or in the professional judgment of the Dean of Students or Director of Residence Life is necessary to protect the physical safety of the student or the community at large.

I hereby authorize any health care facility or health care provider to furnish the Dean of Students, Director of Counseling or the Director of Residence Life medical records and information pertaining to the medical history, mental or physical condition, services rendered, or treatment of the patient named below. This authorization should remain in effect until revoked in writing, or if the student graduates/withdraws from the University. A photocopy of this authorization shall be deemed as valid as the original.

In case of illness or accident deemed serious by BU, I authorize said persons to notify the parent or guardian named on this form, and the Dean of Students if I am unable to do so.

_____ _____

Signature of Student *Date*

_____ _____

Signature of Parent/Guardian (if student is under 18 years of age) *Date*

BRESCIA UNIVERSITY

Health History Form

Name: _____ Date of Birth: _____

Home Address:

_____

Number and Street *City* *State* *Zip Code*

Home Telephone _____ Parent/Guardian _____

Emergency Telephone _____ Emergency Contact _____

1 . Please list any medications to which you are **ALLERGIC** or which you are unable to take for any reason.

_____

_____

2. Please list any medications, either prescription or over-the-counter, that you take on a DAILY basis.

_____

_____

3. Please list all of your **SURGERIES** (i.e., tonsillectomy, appendectomy, etc.)

Year *Surgery* *Reason* *Surgeon*

_____

_____

_____

4. Please list any **SERIOUS/CHRONIC ILLNESS** that you have had before or have now (i.e., diabetes rheumatic fever, etc.)

Year of onset *Illness* *Treatment*

_____

_____

PAST MEDICAL HISTORY

Have you ever had: (check all that apply)

- ❑Chicken Pox
- ❑Diphtheria
- ❑Whooping Cough
- ❑Rheumatic Fever
- ❑Scarlet Fever
- ❑Heart Disease or Murmurs
- ❑Eye problems
- ❑Ear, Nose, Throat problems
- ❑High Blood Pressure
- ❑Hay Fever
- ❑Asthma
- ❑Chronic Cough
- ❑Tuberculosis
- ❑Stomach or Intestinal problems
- ❑Jaundice or Liver Disease
- ❑Appendicitis
- ❑Broken bones

IMMUNIZATION RECORD

Fill in all applicable dates and/or attach copy of Immunization records:

MMR (measles, mumps, rubella) #1_____ #2_____

Polio . #1_____ #2_____ #3_____

Tetanus/Diphtheria #1 _____ #2 _____ #3_____

Tetanus/Diphtheria Booster within last ten years

Hepatitis B .#1_____ #2_____ #3_____

Meningococcal #1 _____

Varicella: Hx of disease ❑yes ❑no or vaccine: _____

Tuberculosis Screening (Mantoux) within last year: _____

Result: ❑Negative ❑Positive CXR Result: _____

HEALTH INSURANCE INFORMATION

Name of company _____

Name of policy holder _____

Policy number _____

Group number _____

PRIMARY HEALTH CARE PROVIDER

_____

Name *Address* *Phone*