CHECK ALL THAT APPLY

- o FRESHMAN
- o SOPHOMORE
- o JUNIOR
- o SENIOR
- o TRANSFER STUDENT

**BENEDICT COLLEGE**
**STUDENT HEALTH SERVICES**
1600 Harden St.
Columbia South Carolina
Ph. (803) 705-4719
Fax (803) 252-7527

## STUDENT HEALTH HISTORY

Last Name_____First Name_____Middle Name_____

Current Age_____Date of Birth_____/_____/_____ Social Security #_____-_____-_____

Cell Phone (___) _____ Home Phone (___) _____

Address_____

City_____State_____ Zip Code_____

**EMERGENCY CONTACT & RELATIONSHIP**

Name_____ Relationship_____

Address_____ Phone # (___) _____

City_____State_____Zip Code_____

## AUTHORIZATION FOR TREATMENT

**THIS IS TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN OF ANY STUDENT UNDER THE AGE OF EIGHTEEN (18)**

I give consent for my student to receive treatment for illness or injury, medication or immunization deemed advisable through the Benedict College Student Health Services Center, and to make the necessary referrals to other facilities, if indicated.

_____

STUDENT SIGNATURE | PARENT/GUARDIAN SIGNATURE | DATE SIGNED

# PERSONAL HISTORY

**History of injuries and/or operations (Give Nature and Year)** _____

_____

_____

**History of previous illness: (Give Year and Status)**

Appendicitis_____ Epilepsy_____ Pneumonia_____

Asthma _____ Kidney Disease_____Rheumatic Fever_____

Cardiac Condition_____Malaria_____ Seasonal Allergies_____

Diabetes_____Mononucleosis_____ Tuberculosis_____

Other_____

Have you ever had any problems or do you have a history of psychological problems? (Be Specific) _____

_____

Have you had any other severe illness **NOT** mentioned above? If so, please explain. _____

Have you ever used any psychoactive or addicting drugs without prescription? _____

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# HEALTH RECORD EXAMINATION
## To be completed by M.D./N.P./P.A.

Name (Last, First, MI): _____ Date of examination: _____/_____/_____

**Tuberculosis Test:** Date Given: _____/_____/_____ Date Read_____/_____/_____Results_____
IF ***POSITIVE*** **MUST** have chest X-Ray: Date of CXR: _____/_____/_____ Results_____

**IMMUNIZATON RECORD**
*****PLEASE UPDATE IF NEEDED*****

Tetanus-Diphtheria (Booster within the last 10 years) _____

M.M.R. (Measles, Mumps, Rubella) Dose 1 _____/_____/_____ Dose 2_____/_____/_____

Measles: Disease Date _____/_____/_____Mumps: Disease Date _____/_____/_____ Rubella: Disease Date_____/_____/_____

Polio: Completed Primary Series? YES NO Date of Last Booster_____/_____/_____

Hepatitis B: Dose 1 _____/_____/_____ Dose 2 _____/_____/_____ Dose 3 _____/_____/_____

Hepatitis A (Optional): Dose 1 _____/_____/_____ Dose 2 _____/_____/_____

Menomune A/C/Y/W-135 (Meningococcal Vaccine) (Optional) _____/_____/_____

Meningococcal Booster (Optional) _____/_____/_____

**Recommended by ACHA (American College Health Association) and Center for Disease Control (CDC)**

Blood Pressure: _____/_____ Pulse_____Respiratory_____ Height_____Weight_____
Medication prescribed (Past 2 yrs. and current) _____
Operations _____

**Please include a separate sheet of paper to explain the status of any chronic Medical, Physical, or Psychological conditions**

| Please check each item (N) Normal or (A) Abnormal | N or A | Remarks | | N or A | Remarks |
|---|---|---|---|---|---|
| Posture | | | Lungs and Chest | | |
| Joints | | | Breast (Females) | | |
| Speech | | | Abdomen | | |
| Skin & Lymphatic's | | | Back and Spine | | |
| Nose and Sinuses | | | Genitourinary System | | |
| Ears | | | Endocrine System | | |
| Mouth, Throat, Tonsils | | | Nutrition | | |
| Oral Cavity | | | Nervous System | | |
| Eyes | | | Menstrual Cycle/Testes | | |
| Heart | | | Emotional Stability | | |

**FOOD/DRUG ALLERGIES:** _____

SIGNATURE OF M.D. / N.P. / P.A._____ OFFICE STAMP

PRINTED NAME_____

PHONE NUMBER_____