

**CHECK ALL THAT APPLY**

- FRESHMAN
- SOPHOMORE
- JUNIOR
- SENIOR
- TRANSFER STUDENT

**BENEDICT COLLEGE  
STUDENT HEALTH CENTER**  
1600 Harden Street  
Columbia South Carolina  
Ph. (803) 705-4719  
Fax (803) 252-7527  
Healthcenter@Benedict.edu

**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 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 \_\_\_\_\_

**IMMUNIZATION 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 _____	