CHECK ALL THAT APPLY

- FRESHMAN
- SOPHOMORE
- JUNIOR
- SENIOR
- TRANSFER STUDENT

BENEDICT COLLEGE
STUDENT HEALTH SERVICES
1600 Harden St.
Columbia South Carolina
Ph. (803) 705-4719
Fax (803) 705-6667
Healthcenter@Benedict.edu

STUDENT HEALTH HISTORY

Last Name_____First Name_____Middle Name_____

Current Age_____Date of Birth_____/_____/_____ BC Student ID #_____ Last 4 SSN_____

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) _____ Flu Vaccine Date: _____/_____/_____

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_____