

**REINHARDT COLLEGE
STUDENT HEALTH SERVICES**

7300 Reinhardt College Circle
Waleska, GA 30183
Office 770-720-5542 Fax 770-720-5901

MEDICAL HISTORY

This is confidential information and will not be released without your written permission.

PART A – TO BE COMPLETED BY STUDENT—DATE _____ Boarding yes / no

I. PLEASE PRINT THE FOLLOWING INFORMATION:

Name: Last _____ First _____ M.I. _____ NICKNAME _____
Birthdate ____ / ____ / ____ SS # ____ / ____ / ____ Sex: Male Female
Home Address _____ CITY _____ STATE _____
Home Phone _____ - _____ - _____ Semester/Year Entering Reinhardt ____ / ____
Home Physician _____ Phone _____ - _____ - _____
Address _____

II. INSURANCE COVERAGE **COPY OF INSURANCE CARD MUST ACCOMPANY THIS FORM**

Name of Insurance Carrier _____
Name of Insured _____ POLICY # _____ GROUP # _____

III. EMERGENCY CONTACTS:

Mother's Name & # _____ Father's Name & # _____
Emergency Contact Name _____ Relationship _____ Phone _____

IV. HEALTH HISTORY

1. Please list any allergies: (Drug, Food, Pollen, Insect, Other) _____

2. MEDICATIONS--List the medications you take frequently or regularly

Medication	Dosage	Condition Requiring Medicine	Dr. Prescribing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Your Health History – Circle any illnesses that apply to you

Alcoholism	Anemia	Arthritis	Asthma	Back Problems
Bladder Infections	Bleeding Tendency	Bronchitis	Cancer	Colitis
Depression	Diabetes	Drug Abuse	Eating Disorder	Epilepsy/Seizures
Hearing Problems	Heart Problems	Hepatitis	Hypertension	Hypoglycemia
Migranes	Mononucleosis	Pneumonia	Shingles	Thyroid Problems
Tobacco Use	Tuberculosis	Vision Problems	Learning Disability	Other _____

DATES AND REASON FOR HOSPITALIZATIONS (INCLUDING TREATMENT FOR MENTAL ILLNESS):

STATEMENT AND SIGNATURE BY STUDENT AND/OR PARENT OR GUARDIAN

All statements in this Health Form are true to the best of my knowledge and I have no abnormality, limitation, or restriction not mentioned in this record. I agree to notify the Reinhardt Health Center of any change that occurs in my physical or mental health, whether such change occurs prior to my registration or while I am a student.

Because the records I have filled out for the Reinhardt Health Center are confidential, I understand that it is my responsibility to inform my Residence Advisor and Housing Director of any health conditions that could present a life-threatening situation.

I give Reinhardt College permission to contact my parents, doctor and/or pharmacy should the need arise.

I have also been provided detailed information concerning the risks associated with Meningitis and the availability, effectiveness, and known contraindications of vaccination.

In the event that I transfer to another college, I give the Reinhardt Health Center permission to release my immunization records(only) to the appropriate authority.

Student's Signature _____ Date _____

Witness _____ Date _____

(Parent, Guardian, or Reinhardt School Official)

PART B – TO BE COMPLETED BY HEALTH PROVIDER

CERTIFICATE OF IMMUNIZATION

MOST IMPORTANT--Legal Documentation is Necessary

The following immunizations are required for entrance into Reinhardt College

1. **Completed primary series of DTP Immunizations
(Tetanus received within the past 10 years)**
2. **Complete series of Measles, Mumps, Rubella Immunizations
(or: record of having the diseases, or records of immune titer)**
3. **Meningococcal Vaccine Information to be read and signed by ALL
Residential Students (NEW State Requirement as of 1/01/04)**

****The legal immunization form can be mailed, faxed (770-720-5901)
or a copy can be attached to this document.**

Please send this document directly to the following address:

**Reinhardt College Health Center
7300 Reinhardt College Circle
Waleska, Georgia 30183**