MEDICAL HISTORY

PLEASE PRINT IN BLACK INK

*provision of social security number is voluntary and is requested solely for administrative convenience and record-keeping accuracy

NAME: LAST ______ FIRST ______ MIDDLE ______ GENDER ______ DATE OF BIRTH ______ SOCIAL SECURITY NUMBER* ______

PERMANENT ADDRESS: STREET ______ CITY ______ STATE ______ ZIP CODE ______ RELATIONSHIP ______

HOME PHONE: ______ STUDENT MOBILE: ______ PARENT MOBILE: ______

EMERGENCY CONTACT INFORMATION

NAME ______ RELATIONSHIP ______ ADDRESS ______

HOME PHONE: ______ WORK PHONE: ______ CELL PHONE: ______ OTHER: ______

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. As needed, attach additional sheets for fuller explanations.

ALLERGY INFORMATION

List any food, drug, or contact allergies and type of reaction ______

______

DO YOU REQUIRE AN EPI-PEN FOR ALLERGIC REACTIONS? YES ______ NO ______

(IF YES, YOU ARE REQUIRED TO BRING TWO (2) EPI-PENS TO CAMPUS. IF ATHLETE, MUST BRING ADDITIONAL (3RD) EPI-PEN TO ATHLETIC TRAINING STAFF.)

HAVE YOU EVER HAD, OR DO YOU NOW HAVE : (check if applicable and indicate when and how long as well as any comments)

Condition	Yes	Dates of occurrence, any other comments
Chest pain with or after exertion		
Elevated blood pressure		
Dizziness with or after exercise		
Racing heart/irregular heart rhythm		
Heart murmur		
Fainting		
Anemia		
Asthma		Athletes: if on inhaler, bring one for trainer
Shortness of breath		
Pneumonia		
Seasonal allergies/sinusitis		
Strep throat		
Arthritis		
Any orthopedic injury (specify type)		
Surgery/rehabilitation		
Heat exhaustion or intolerance		
History of hypothermia		
Female: irregular or painful periods		
Male: testicular problem (testes)		
Urinary tract infection(kidney/bladder)		
Headaches/migraines		
Concussion		List how many and dates of occurrence
Seizures/epilepsy		
Gall bladder disease or ulcers		
Diabetes		Insulin pump?
Hernia		
Irritable bowel syndrome		
Chronic diarrhea or constipation		

Weight problem: or recent gain/loss		
Mental health issues (specify)		
Learning disability/ADHD		
Anorexia/bulimia		
Bi-polar		
Depression		
Other :		

Condition	Yes	Dates of occurrence, any other comments
Chronic fatigue syndrome/ fibromyalgia		
Sexually transmitted disease		
Cancer		
Thyroid disease		
Medically prescribed diet or fad diet		
Dental plates or orthodontics		
Tuberculosis		
Malaria		
other		
Have you ever used or do you now use: (check if applicable and indicate when and how long as well as any comments)		
Use of cigarettes, chewing tobacco		
Use of marijuana		
Use of alcohol		
Use of recreational drugs		
Use of steroids or creatine		
Use Of vitamins, supplements, herbs		
Use of weight loss meds, incl. laxatives		

Have you ever been hospitalized?_____ Specify and include dates: ______________________________________

Do you have any other medical/mental health concerns you wish to specify?

What kind of swimmer are you? Non-swimmer______weak______average______good_____very strong_____

Do you exercise three or more times per week? Yes__ No__

Do you use a seatbelt on a regular basis? Yes__ No __

Current medications (prescription or non-prescription)			
Name of med/vitamin, birth control pill, etc	Dosage	How long have you been on the medication?	Used for:

PLEASE BRING ALL MEDICATION NEEDED WITH YOU TO COLLEGE

Please read the following information about meningococcal disease:

Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. College freshmen, particularly those living in dormitories or residence halls, are at a modestly increased risk for meningococcal disease compared with persons the same age that are not attending college.

What is meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

What are the symptoms? Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion. **Who is at risk?** Certain college students, particularly freshmen who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.

Can meningitis be prevented? Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals.

For more information: Visit the website of the Centers for Disease Control and Prevention (CDC) at: www.cdc.qov/ncidod/dbmd/diseaseinfo or at www.cdc.qov/nip@ublications/ACIP-list.htm. Or visit the website of the American College Health Association, www.acha.org. To obtain the vaccination, contact your personal physician or health department, or call **Asheville Infectious Disease Consultants** in Asheville, North Carolina at (828) 258-9635

STATEMENT BY STUDENT OR PARENT/GUARDIAN (IF STUDENT IS UNDER AGE 18):

I have personally supplied (reviewed) the information on this two page history and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to Montreat College to release information from my (son/daughter's) medical record to a physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and/or medical care. I authorize copies of this medical record to be released to the athletic, physical education, and outdoor education departments, in accordance with requirements from those departments. I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by a licensed medical practitioner.

____ ________________________

Signature of Student Date

____ ________________________

Signature of Parent/Guardian, if student under age 18 Date