

Harris-Stowe State University
 3025 Laclede Ave.
 St. Louis, MO 63103

Harris-Stowe



State University Health Record

Phone: (314) 340-5005
 Fax: (314) 340-5520

CLASSIFICATION

First-Year
 Sophomore
 Junior
 Senior
 Transfer
 Date of Entrance _____

EACH AND EVERY QUESTION MUST BE ANSWERED. Incomplete records will be returned. Please type or print answers.

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

This record must be completed and returned to Harris-Stowe State University by July 27, 2012

NAME _____ I.D. _____
FIRST MIDDLE LAST

Date of Birth _____ GENDER: Female Male SSN# _____

Home Address _____ Cell Phone () _____
STREET CITY STATE ZIP

Parent or Guardian _____ Relationship _____

Parents' Address _____

Parents' Home Phone () _____ Parents' Cell Phone () _____ Business Phone () _____
STREET CITY STATE ZIP

Emergency Contact: Name/Relationship _____ / _____ Phone () _____

FAMILY HISTORY

Father: Living Deceased
 Occupation _____ Siblings: _____
 Age of Death _____ No. of Living _____
 Cause of Death _____ No. of Deceased _____
 Do you have a twin? _____
 Yes No

Mother: Living Deceased
 Occupation _____
 Age of Death _____
 Cause of Death _____

Have any of your family members experienced the following?
 Diabetes High Blood Pressure Heart Disease
 Kidney Disease Cancer (type : _____)
 Emotional Problems Psychiatric Problems Eating Disorders
 Depression Anxiety Alcoholism Substance Abuse
 Suicide

Please identify all currently used medication _____

PERSONAL HISTORY Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No
Asthma			Seizures/Blackouts			Scarlet Fever		
Cancer			Other Chronic Illness			German Measles		
Diabetes			Head Injury			Measles		
Polio			Recurrent Headaches			Mumps		
Tuberculosis			High/Low Blood Pressure			Chicken Pox		
Heart Disease			Anxiety/Depression			Infectious Mononucleosis		
Rheumatic Disease			Psychiatric Treatment			Recent Weight Change		
Explanation and Dates:								
	Yes	No		Yes	No	ALLERGIES	Yes	No
Appendectomy			Gum/Dental Disorder			Penicillin		
Tonsillectomy			Bone/Joint Disease			Sulfa		
Hernia Repair			Kidney/Bladder Disease			Codeine		
Other Operations			Wear Contact Lenses			Wasp/Bee Stings		
Females:			Wear Hearing Aid			Foods		
Menstrual Problems			Other Disabilities/Needs			Receives Allergy Shots		

Explanation and Dates: (Attach another page if necessary)

HEALTH INSURANCE

Please provide Health Services with a copy (front & back) of your insurance I.D. card.

_____ I will use private insurance

AUTHORIZATION FOR MEDICAL PROCEDURES:

Permission is hereby granted to Health Services at Harris-Stowe State University to authorize medical and surgical services, including physician ordered injections or required authorized and requested to refer the student to a duly licensed physician or hospital, and such physician or hospital is authorized to administer such treatment or surgery as appears prudent under the circumstances then existing.

SIGNATURE OF STUDENT (if student is 18 or over)

SIGNATURE OF PARENT OR GUARDIAN (if student is 17 or under)