

# Avila University Health Services Information Form

*This form is confidential and kept on file in Health Services as a part of your health record.*

## PERSONAL INFORMATION

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Permanent Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Permanent Telephone (\_\_\_\_\_) \_\_\_\_\_ Gender \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## PERSON TO NOTIFY IN CASE OF EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Business Telephone (\_\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holder \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

## PERMISSION TO TREAT

I hereby authorize and give my consent to the health authorities of Avila and/or their designee for any necessary medical or surgical treatment. This authorization covers immunizations, injections, minor procedures, anesthesia and/or hospitalization in case of serious accident, illness, or injury.

The student is financially responsible for any medical expenses, hospital expenses, and/or treatment by a physician. This applies even when the student is transported in an emergency by Emergency Medical Services or by Avila personnel. Students are strongly urged to carry adequate health insurance.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Guardian (if student is under 18) \_\_\_\_\_ Date \_\_\_\_\_

## PROOF OF IMMUNIZATION (Please submit one of the following)

- A personal record signed by a health-care giver or a physician or clinic report. **OR** • A copy of your school immunization record.

Dates of Immunizations (Month, Day and Year)

MMR \_\_\_\_\_  
Measles, Mumps, Rubella - 2 doses recommended

Td \_\_\_\_\_  
Tetanus-Diphtheria — Booster needed every 10 years

Hepatitis B \_\_\_\_\_  
3 dose recommended

Meningococcal \_\_\_\_\_  
1 dose recommended

(continued on back)

**HEALTH HISTORY**

Please check any of the following conditions which apply to you.

	YES	NO
Allergies to food/medications	___	___
Current medication	___	___
Current medical treatment	___	___
Operations or serious injury	___	___
Special dietary requirements	___	___
Vision problems, glasses or contacts	___	___

If answered "YES" to any of the above, please elaborate:

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HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

**FEMALE — MENSTRUAL HISTORY**

	YES	NO
Irregular periods	___	___
Severe cramps	___	___

List medications used for discomfort:

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	YES	NO
Chicken Pox	___	___
Bleeding Disorder	___	___
Anemia	___	___
High/Low Blood Pressure	___	___
Heart Disease	___	___
Rheumatic Fever	___	___
Asthma/HayFever	___	___
Ear, Nose, Throat Conditions	___	___
Infectious Mono	___	___
Headaches	___	___
Fainting/Dizziness	___	___
Convulsions/Epilepsy	___	___
Diabetes	___	___
Ulcers/Indigestion	___	___
Recurrent Constipation	___	___
Diarrhea	___	___
Weight Loss/Gain	___	___
Hepatitis	___	___
Bone/Joint Pain	___	___
Back Problems	___	___
Gum/Tooth Problems	___	___
Difficulty Sleeping or Sleep Disorder	___	___
Depression	___	___

If you answered "YES" to any of the above, please elaborate:

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Have you ever received treatment for emotional problems? YES \_\_\_ NO \_\_\_ Were you hospitalized? YES \_\_\_ NO \_\_\_

If you answered "YES," please elaborate:

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Please list any special medical requirements, disabilities, or other health concerns (emotional or physical) that you have:

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