



STUDENT IDENTIFICATION

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Last name

First name

Middle name

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OU ID Number

Female/Male

Date of birth

Place of birth

PARENTS, GUARDIANS, OR PERSON TO CONTACT IN AN EMERGENCY

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Last name

First name

Middle initial

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Street Address

Apt. No.

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City

State

ZIP code

Daytime telephone number:

MEDICAL HISTORY

A. List and explain any significant health problems (either medical or psychiatric) which might have an effect on your functioning as an Ohio University student:

1.

2.

3.

B. List any surgical operations which you have undergone:

C. List any illnesses which occur at a high rate in other family members which might be a problem during your time as an Ohio University student:

SOCIAL HISTORY

Have you ever had a substance abuse problem (alcohol, marijuana, injected drugs)?

Yes No

Do you use tobacco?

Yes No

ALLERGIES

List all drugs (medicines) to which you have had an allergic reaction. Indicate the nature of the reaction. none the following:

1. _____
2. _____
3. _____

List any medicines which you do not tolerate well. Include the side effects which you have experienced with these medicines. Medicines that you are allergic to should be listed above under ALLERGIES.

1. _____
2. _____
3. _____

MEDICATIONS

List all medicines which you take on a regular basis and which you expect to continue to use while a student at Ohio University.

1. _____
2. _____
3. _____
4. _____

IMMUNIZATION DATES

DPT (diphtheria/pertussis/tetanus)	1. _____	2. _____	3. _____
Td (tetanus/diphtheria booster)	1. _____	2. _____	
OPV (oral polio vaccine)	1. _____	2. _____	3. _____
MMR (measles/mumps/rubella)	1. _____	2. _____	
HepB (hepatitis B)	1. _____	2. _____	3. _____
others (specify) _____	1. _____		
_____	2. _____		

AUTHORIZATION

I authorize and request the Ohio University Student Health Service to administer all requested and/or indicated outpatient medical and surgical services and immunizations and to perform emergency procedures, as necessary, or to refer to other duly licensed medical personnel for necessary emergency treatment when indicated, including transfer to outside hospitals. I also authorize any physician, healer, practitioner, clinic or hospital having treated me in the past for any medical condition to release to the physicians of the Student Health Service all details of the care rendered.

student's signature

date

signature of parent or guardian
(if student is less than 18 years old)

date