



Health History Consent and Release Form

Lourdes University maintains health records on all students in order to help medical professionals facilitate proper health care in the event of an emergency. It is essential to have background medical history information and immunization records on new students. To assist us in this process, we ask all new students to complete a Health History Form/Immunization Record. The completed form as well as the Consent and Release form below should be returned with your Housing Contract.

CONSENT AND RELEASE

I certify that I understand the contents of this form, and that my signature represents a free and voluntary act of consent thereto on behalf of the student named below. I further certify that I expect my specific information regarding service from Lourdes University will not be released without the express written consent of the Student unless disclosure is mandated by law or in the professional judgment of the Dean of Students or Director of Residence Life is necessary to protect the physical safety of the student or community at large.

I hereby authorize any health care facility or health care provider to furnish the Dean of Students, Director of Counseling or the Director of Residence Life medical records and information pertaining to the medical history, mental or physical condition, services rendered, or treatment of the patient named below. This authorization should remain in effect until revoked in writing, or if the student graduates/withdraws from the University. A photocopy of this authorization shall be deemed as valid as the original.

In case of illness or accident deemed serious by Lourdes University, I authorize said persons to notify the parent or guardian named on this form, and the Dean of Students if I am unable to do so.

Signature of Student

Date

Signature of Parent/Guardian (if student is under 18 years of age)

Date

HEALTH HISTORY

Name _____ SS# _____ Date of Birth ____/____/____

Last

First

M. I.

Entering LC as a:

Freshman

Transfer

Grad Student

Summer 20_____

Fall 20_____

Spring 20_____

Personal History

(PLEASE PRINT)

Name _____

Last

First

M. I.

HAVE YOU HAD? (mark choice)	Yes	NO	HAVE YOU HAD? (mark choice)	Yes	NO
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		

Kidney Disorders			Chicken Pox Illness		
Bladder Disorders			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems-Specify below:		
Surgeries:					
Hospitalizations:					

List any medications that you are allergic to? _____

List any allergies to food, latex, herbal and over-the-counter medications? _____

List any other allergies? _____

List any medication you are currently taking? _____

Any other disease, illness, past surgeries, permanent disabilities or concerns?

Are you currently being treated by a health care professional? If yes, explain _____

Date

Please Print or Type

Student Last Name, First Name, MI			Social Security # (Last 4 digits)		
Address					
City		State		Zip	
Telephone	Cell Phone	Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Emergency Contacts

Parents/persons to be contacted in case of an emergency.

Please list two contacts.

1. Name	Relationship	Home Phone
Address		Indicate Cell or Work phone
2. Name	Relationship	Home Phone
Address		Indicate Cell or Work phone

PRIMARY CARE PHYSICIAN

Address	Phone
	Fax

INSURANCE INFORMATION

Complete data below and attach copies of both sides of your insurance and prescription cards.

Insurance Co. Name	Member Benefits Phone Number		
Address (to send claims)			
City	State	Zip	
I.D. #	Group #.		
Insured's Name (policyholder/responsible party)	Insured's SS#	Insured's Birth Date	Relationship to Insured <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Prescription Card Name	Sponsor #	Card Member #	Customer Service Phone #