HEALTH SERVICES
STUDENT HEALTH RECORD

THIS FORM MUST BE COMPLETED BY:
** ALL UNDERGRADUATE STUDENTS **

PARENTAL PERMISSION (Required for students under age 18)

The law requires that parental permission be obtained for procedures on minors. The following consent form must be signed by the parent so that such procedures may be promptly carried out so that unnecessary delays will not occur with operative procedures. HOWEVER, NO OPERATION WILL BE PERFORMED, EXCEPT IN EXTREME EMERGENCY, WITHOUT PARENTS BEING CONTACTED AND FULLY INFORMED.

I give my permission for such emergency diagnostic, therapeutic and operative procedures as deemed necessary for my son/daughter.

___________________________________________________________________________________________________

(Student’s Name) Date _________/_________/_________
(First Name) Relationship __________________________
(Last Name) (Parent or Guardian’s Signature)

This form is the foundation of the Student’s Medical Record at Monmouth University, and is regarded as confidential.

Each question must be completed and the form returned to the University Health Services, BEFORE the student begins classes.

This is a confidential record.

NOTE: In the event of illness...

Due to the complexity of HMO’s and managed care insurance, students may be required by these plans to contact their primary care physicians when services outside the Health center are recommended.

The student, NOT the University is financially responsible for any hospital expenses and for treatment by a physician other than the University Physician, even though the student may have been transported, in an emergency, by the University personnel.

PLEASE RETURN THIS FORM TO:
HEALTH SERVICES
MONMOUTH UNIVERSITY
400 CEDAR AVENUE
WEST LONG BANCH, NJ 07764-1898

☐ Check if intercollegiate athlete and enter sport __________________________________________________________
Check if: ☐ Residential Student ☐ Non-residential student
MEDICAL HISTORY
(TO BE COMPLETED BY ALL UNDERGRADUATE STUDENTS)

PLEASE PRINT IN INK OR TYPE:

Name ___________________________________________ ID # __________________________
   (Last)    (First)     (M.I.)
Home Address ______________________________________ Phone ______________________
Local Address ______________________________________ Phone ______________________

Age _____ Date of Birth _____/____/____ Sex M ☐ F ☐ Date Entering: Fall 20____, Spring 20____, Summer 20____

Parent/Guardian/Spouse/ or next of kin: Family Physician:
Name ___________________________________________ ________________________________
Address ___________________________________________ ________________________________
   (Number, Street, City, State, Zip)   (Number, Street, City, State, Zip)
Phone ( ) ___________________________ Phone ( ) ___________________________

ARE YOU COVERED BY MEDICAL INSURANCE? Yes ☐ No ☐ ID Number __________________

Policy/Company Name __________________________________________________________

FAMILY HISTORY
Has any member of immediate family had any of the following conditions: (give their relationship):

Allergy ________ Diabetes ________ High Blood Pressure ________ *Tuberculosis ________
   Asthma ________ Epilepsy ________ Kidney Disease ________ Ulcers ________
   Cancer ________ Heart Condition ________ Mental Illness ________ Sickle Cell Anemia ________
   Colitis ________ Hemophilia ________ Stroke ________ Other ________

PAST HISTORY – IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, STATE YEAR OF OCCURRENCE

Anemia ________ Eating Disorder ________ Meningitis ________
   Arthritis ________ Emotional Disorder ________ Migraine Headaches ________
   Asthma ________ Epilepsy or Convulsions ________ Orthopedic Problem ________
   Bladder Infection ________ Heart Disturbances ________ Phlebitis ________
   Bleeding Tendency ________ Head Injury ________ Pneumonia ________
   Bronchitis ________ Hepatitis ________ Psychological Problems ________
   Cancer ________ Hearing/Ear ________ Rheumatic Fever ________
   Chicken Pox ________ High Blood Pressure ________ Thyroid Disturbances ________
   Cholesterol ________ Infectious Mononucleosis ________ *Tuberculosis ________
   Colitis ________ Kidney Disorder ________ Ulcers ________
   Cystic Fibrosis ________ Lyme Disease ________ Visual/Eye ________
   Diabetes ________ Malaria ________ Other ________

*Has the student ever lived with anyone who had tuberculosis Yes ___ No ___ Length of Time ______

SURGERIES:

MEDICATIONS: List all medications with dosages and frequency or administration

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>REASON FOR TAKING MEDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

ALLERGIES

Allergies –Medication: _________________________________________________________________
   Food ___________________________________________________________________________
Are allergy injections being prescribed at present? ____________________________________

Do you drink alcohol? ________ How often? ______________ Do you smoke? ________ How often? ______________

Have you been diagnosed with a learning, psychological or physical disability? Yes ____ No ____
If Yes, please explain: ______________________________________________________________________

Students seeking accommodations for a disability contact: Department of Disability Services.
Students seeking psychological support contact: Counseling & Psychological Services
Exam Required of ALL Intercollegiate Sport Athletes and Cheerleaders ONLY

PLEASE PRINT:

NAME ________________________________ DATE ________________________________

(Last) (First)

Date of Birth ____________________________ ID # ____________________________ Male ______ Female ______

Home/Permanent Address ________________________________ ________________________________

☐ Check if athlete; enter sport ____________________________ Telephone # ________________________________

To Be Completed By Health Care Provider

Height ____________ Weight ____________ Blood Pressure ____________ Pulse ____________

Gross Hearing Defects: Yes _____ No _____ Vision: OD _____ OS _____ Corrected: Yes _____ No _____

List Current Medications: ____________________________ Allergies: ____________________________

NORMAL EXAM ABNORMAL EXAM/COMMENTS

HEENT ____________________________ ____________________________

HEART ____________________________ ____________________________

LUNGS ____________________________ ____________________________

IF ASTHMATIC – baseline peak flow rate ____________________________ ____________________________

ABDOMEN ____________________________ ____________________________

PELVIS ____________________________ ____________________________

NEUROLOGICAL ____________________________ ____________________________

MULTICULOSKELETAL ____________________________ ____________________________

Range of Motion/Strength ____________________________ ____________________________

Gait ____________________________ ____________________________

Spine ____________________________ ____________________________

GENERAL ____________________________ ____________________________

URINE dipstick/analysis ____________________________ ____________________________

• Is this individual currently being treated for any medical problem(s)? If YES, give details below. NO _____

• Is there a loss or seriously impaired function of any paired organ (i.e. kidney, testicle, ovary)? If YES, give details below. NO _____

• Is there a history of any psychological problem in the last 5 years? If YES, give details below. NO _____

• Is there any reason this individual cannot participate in competitive Division I – Intercollegiate Athletics – which includes strenuous exercise/conditioning, contact and collision? If YES, give details below. NO _____

DETAILS: ________________________________________________________________

______________________________________________________________

Name of Physician: ____________________________ Date: ____________ Signature ____________________________

Address: ____________________________ ____________________________ Telephone ____________________________

***PLEASE STAMP THIS FORM***

Mail this form to: Monmouth University Health Services, 400 Cedar Ave., West Long Branch, NJ 07764-1898