Attention Return This Form To:
Residential Life and Health Service

Allen University
1530 Harden Street
Columbia, SC 29204
Phone: 803-376-5730

Classification (Circle one): Freshman Sophomore Junior Senior Readmit Transfer Student

STUDENT CONTACT INFORMATION

Last Name: ____________________________First Name: _____________________ Middle Name:_________
Current Age: _____ Date of Birth: _____/_____/_____ Social Security #:_______-_______-_______
Cell Phone: (______)_________________________ Home Phone: (______)_________________________
Address:____
City:___________________________________ State:________________________ Zip:______________

EMERGENCY CONTACT & RELATIONSHIP

Last Name:________________________________First Name:_______________________________________
Address:____
City:__________________________________ State:________________________ Zip:_______________
Cell Phone: (______)_________________________ Home Phone: (______)_________________________
Relationship:____

AUTHORIZATION FOR TREATMENT		
THIS IS TO BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN OF ANY STUDENT UNDER THE AGE OF EIGHTEEN (18)		
I give consent for my student to receive treatment for illness or injury, medication or immunization deemed advisable through the Benedict College Student Health Services Center, and to make the necessary referrals to other facilities, if indicated.		
_______________ Student Signature	_______________ Parent Signature	_______________ Date Signed

STUDENT PERSONAL HEALTH HISTORY

History of injuries and/or operations (Give Nature and Year): _____________________________________
____
____

History of previous illness: (Give Year and Status)		
Appendicitis	Epilepsy	Pneumonia
Asthma	Kidney Disease	Rheumatic Fever
Cardiac Condition	Malaria	Seasonal Allergies
Diabetes	Mononucleosis	Tuberculosis
Other		
Have you ever had any problems or do you have a history of psychological problems? (Be Specific)		

Have you had any other severe illness NOT mentioned above? If so, please explain: ______________________
____

Have you ever used any psychoactive or addicting drugs without prescription? ___________________________
____
____

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HEALTH RECORD EXAMINATION
To be completed by M.D./N.P/P.A.

Name (Last, First, MI):	Date of examination: _______/________/________	
Tuberculosis Test Date Given: ______/_______/______	Date Read: _____/_____/_____	Results:
Results:	If POSITIVE, must have chest X-ray	Date of CXR:_____/_____/_____

IMMUNIZATION RECORD ***PLEASE UPDATE IF NEEDED
Tetanus-Diphtheria (Booster within the last 10 years) _____/_____/_____
M.M.R.(Measles, Mumps, Rubella) Dose 1:_____/_____/____ Dose 2 _____/_____/_____
Measles: Disease Date: _____/_____/_____ Mumps: Disease Date:_____/_____/_____ Rubella: Disease Date:_____/_____/___
Polio: Completed Primary Series? Circle One YES or NO Date of Last Booster: _____/_____/_____
Hepatitis B: Dose 1:_____/_____/____ Dose 2 _____/_____/_____ Dose 3 _____/_____/_____
Hepatitis A (Optional): Dose 1:_____/_____/_____ Dose 2:_____/_____/_____
Menomune A/C/Y/W-135 (Meningococcal Vaccine) (Optional): _____/_____/_____
Meningococcal Booster (Optional):_____/_____/_____
Recommended by ACHA (American College Health Association) and Center for Disease Control (CDC)

Blood Pressure: _____/_____ Pulse:_________ Respiratory: __________ Height: __________ Weight:__________
Medication prescribed (Past 2 years and current)____
Operations:____
____

Please include a separate sheet of paper to explain the status of any chronic Medical, Physical, or Psychological conditions

Check each item(N) Normal or (A) Abnormal	N or A	Remarks		N or A	Remarks
Posture			Lungs and Chest		
Joints			Breast (Females)		
Speech			Abdomen		
Skin & Lymphatic's			Back and Spine		
Nose and Sinuses			Genitourinary System		
Ears			Endocrine System		
Mouth, Throat, Tonsils			Nutrition		
Oral Cavity			Nervous System		
Eyes			Menstrual Cycle/Testes		
Heart			Emotional Stability		

FOOD/DRUG ALLERGIES:____
_

Signature of M.D./N.P./P.A______________________________
Printed Name:____
Phone Number:_______________________________________

Office Stamp Here