

Please complete in ink or type only! Faxes or copies will not be accepted.

All documents must be uploaded to the Student Portal via the Medicat icon.

Deadline for Submission:

Fall Semester: **June 1**
Spring Semester: **December 1**

Student Health Services
Brazeal Hall Box 140064
Morehouse College
830 Westview Dr. SW
Atlanta, Georgia 30314
(404) 215-2637

The Pre-Entrance Health Record is required before you are allowed to move in to campus housing or enroll at Morehouse College. The student, parent/guardian and doctor must complete this Pre-Entrance Health Record.

- Failure to provide important medical information could result in unnecessary lab tests or screenings.
- Please make copies of the completed Pre-Entrance Health Record for your records.
- To access the Patient Portal, log in to www.myportal.morehouse.edu and click the following icon.



PART I

To be completed by the student and parent for authorization to treat.

Clearance to move in to campus housing or registration for classes will not be granted until all Pre-entrance health requirements have been met.

Please upload your completed health forms to the Student Portal via the Mediat icon.

NAME _____
Last First MI

PERMANENT HOME ADDRESS _____

City State Zip Country

SSN # HOME PHONE CELL PHONE

EMAIL ADDRESS _____

DATE OF BIRTH AGE MOREHOUSE ID#

ENROLLMENT DATE (Semester/Year) FALL/ Spring/

ENROLLMENT CLASSIFICATION: Regular F/T Regular P/T International Transfer Guest
Exchange/International Exchange-Domestic

AUTHORIZATIONS: (Parent or legal guardian MUST sign if under 18 years of age) I hereby accept financial responsibility for the expense of health care services and I authorize the medical providers of Morehouse College Student Health Services and their agents or consultants, including emergency medical technicians, area hospitals or other treatment facilities, to perform diagnostic and treatment procedures, on the above named student, which in their judgment may become necessary while he attends Morehouse College. I have no expectation for Morehouse College to pay medical expenses for the student should he need treatment outside of Student Health Services. I agree to absolve and hold harmless Morehouse College in making medical decisions for the student. I understand that every effort will be made to notify the parent or legal guardian once permission is obtained from the student in the event of a major illness or injury. I understand that the parent or guardian may not necessarily receive notification prior to treatment.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

EMERGENCY CONTACT PERSON:

NAME RELATIONSHIP

ADDRESS

DAY TIME PHONE NUMBER () NIGHT TIME PHONE NUMBER ()

Secondary Emergency Contact

NAME RELATIONSHIP

ADDRESS

DAY TIME PHONE NUMBER () NIGHT TIME PHONE NUMBER ()

[TO BE COMPLETED BY STUDENT HEALTH SERVICES PERSONNEL]

Status: Complete Reviewed By: _____ Date _____

Incomplete Checklist Indicating Missing Information Sent 1st Date Returned _____ 2nd Date returned _____

PART II

MUST BE COMPLETED BY MEDICAL PROVIDER

Name of Student: _____

This form must be completed and signed by your health care provider based on an examination. ALL ITEMS ARE REQUIRED!!

DRUG ALLERGIES: Yes No If yes, to what? PCN Sulfa Erythromycin other _____

If yes, what is the nature of the reaction? _____

FOOD ALLERGIES: Yes No If yes, to what? _____

If yes, what is the nature of the reaction? _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____ BMI _____

Is this student receiving treatment or care for any acute or chronic medical condition? Yes No If yes, please explain _____

Does this student require special accommodations because of any chronic medical condition? Yes No If yes, what is the medical condition and the special accommodations required _____

Is this student receiving therapy for any emotional or psychiatric condition? Yes No If yes, please explain _____

Does this individual require special accommodations because of the emotional or psychiatric condition? Yes No If yes, what accommodations are required? _____

Has this individual had any surgical procedures? Yes No If yes, please explain _____

Are there any learning disabilities or learning challenges that require medication for management? Yes No If yes, please explain indicating medication, dosage and frequency. _____

Does the student have food issues requiring special diet? Yes No If yes, please explain the nature of the food issue and specific diet required _____

May the student participate in an athletic, sports or college wellness program? Yes No If no, please explain _____

Physician Signature and Official office stamp required – May not be signed by a family member

M.D./D.O./N.P./P.A.'s Name (please print) _____

Signature _____

Address _____

Date of Exam _____ Telephone number () _____

Name of Student: _____

MEDICAL HISTORY AND DOCUMENTATION OF NEED FOR SPECIAL ACCOMODATION

Specific requests for accommodations must be initiated by completing the **Counseling & Disability Services Verification and Request for Accommodation** form. Please list all medications and nonprescription medications this student currently takes, as well as the dosage.

REQUIRED SCREENING FOR TUBERCULOSIS (Within the past 12 months)

The PPD skin test must be **placed and read** before the student will be allowed to move into campus housing. Quantiferon Gold blood test also **accepted with lab documentation**. NOTE: If PPD is greater than 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment or other TB prophylaxis treatment should be initiated. *NOTE: PPD test should be mantoux within the past year (*tine or momovac not acceptable*).

	Date Placed	Date Read	Results
PPD*	_____	_____	_____

If positive, provide _____ mm induration (horizontal diameter) Note: *If greater than 10mm induration, chest X-ray required with documentation.* X-Ray results: Normal Abnormal.

If chest x-ray is abnormal, has patient begun INH treatment or other TB prophylaxis treatment? Yes No

If no, please explain _____

Received BCG: Yes No If yes, chest X-Ray required with documentation. X-Ray results: Normal Abnormal

REQUIRED SCREENING FOR SICKLE CELL (ATHLETES ONLY)

Sickle Cell Results: Normal Trait Disease

Sickle Cell date of test: _____

Physician Signature and Official stamp Required – May not be signed by a family member

M.D./D.O./N.P./P.A.'s Name (please print) _____

Signature _____

Address _____

Date of Exam _____ Telephone number () _____

CERTIFICATE OF IMMUNIZATION

Student ID: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Term/Year of Application: _____ Age at time of application: _____ Date of Birth (mm/dd/yyyy): ____/____/____

REQUIRED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for USG Students documentation)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR ¹	/ /	/ /			
Hepatitis A ²	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /
Meningococcal ACWY ^{4,5} (MCV4)	/ /	/ / MCV4 Booster ⁶			
Meningococcal B ⁶	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	
Varicella ²	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough) ³	/ / Tdap	/ / Td Booster ³			
Hepatitis B ²	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /

1—Not required if born before 1957. 2—Required for all US born students born in 1980 or later; all foreign born students regardless of year born. 3 – Td booster only necessary if > 10 years since Tdap dose. 4 – Required if residing in campus housing, sorority housing, or fraternity housing. 5 – MCV4 Booster necessary if initial MCV4 dose was received more than 5 years to admittance. 6 – Consider if younger than 23 years of age.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

- This student is exempt from the above immunizations on the ground of permanent medical contraindication.
- This student is temporarily exempt from the above immunization until ____/____/____ (mm/dd/yyyy)

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____ Signature: _____

Address: _____

Date of Issue: ____/____/____ Telephone: _____

PART III

Name of Student: _____

Please answer each question to the best of your ability. Your answers will help us better serve your fitness needs as a new student.

- None (No exercise activity)
- Light (Slow walking, limited activity, non-structured exercise)
- Moderate (Cardiovascular exercise (walk, run, aerobic, yoga, etc.) for thirty (30) minutes, days per week?

1-2 _____
 3-4 _____
 5 _____
 6-7 _____

- Heavy/Intense (Walk 30-40 minutes, 3-4 or more times per week, structured exercise, weight training days per week?)

1-2 _____
 3-4 _____
 5 _____
 6-7 _____

- Strength, (Resistance training, days per week?)

1-2 _____
 3-4 _____
 5 _____
 6-7 _____

If you participated in a formal wellness class, what would be accomplished by participating in a fitness program? (Please check all that apply.)

- | | | |
|--------------------------------------------------|-------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Reduce Pain | <input type="checkbox"/> Improve Posture | <input type="checkbox"/> Increase Cardiovascular Endurance |
| <input type="checkbox"/> Increase Strength | <input type="checkbox"/> Prevent Surgery | <input type="checkbox"/> Gain Weight: _____ lbs |
| <input type="checkbox"/> Increase Function | <input type="checkbox"/> Improve Flexibility | <input type="checkbox"/> Prepare for Surgery |
| <input type="checkbox"/> Return to Full Activity | <input type="checkbox"/> Lose Weight: _____ lbs | <input type="checkbox"/> Other: _____ |

On average, how many fruits and vegetables do you consume daily?

0 servings per day _____
 1-2 servings per day _____
 3-4 servings per day _____
 5 or more servings per day _____

How much water do you drink daily?

Ounces _____
 Glasses _____

On average, how much sleep do you get each night?

Less than four (4) hours _____ Four (4) to five (5) hours _____
 Six (6) to seven (7) hours _____ More than seven (7) hours _____

Do you struggle to stay awake in the daytime? _____ Yes _____ No

Student Health Insurance

Morehouse College requires all degree-seeking students to have health insurance or purchase the College sponsored plan. All students are charged for the college-sponsored plan up front, however you may elect to waive or opt out of this plan.

In order to “**opt out of enrollment**” in the college sponsored plan, students and families must provide evidence of current enrollment in a health insurance plan licensed to do business in the United States, with a claims payment office with a U.S. phone number and offers an Annual Maximum comparable to the student health insurance offered by the college.

This coverage includes medical and mental health care, within the Atlanta area, that extends beyond **emergency-only** coverage and covers pre-existing conditions as well as prescription drugs.

If you do not wish to purchase the college sponsored plan, you **must opt out or waive the plan by** the deadline of **September 6th for fall enrollment** and **December 20th for spring enrollment**.

If your request to waive or opt out is declined, you will receive notification through the email address you used to complete the waiver along with instructions to appeal by printing the “**Appeal/Insurance Verification**” form and submitting this to your insurance carrier.

Failure to opt out or waive the college sponsored student health insurance plan will result in a fee being added to the student’s account. If you wish to enroll in the college-sponsored plan, do nothing; the fee will be added to your account!

MEDICAL INSURANCE INFORMATION

Completion of this portion of the form does **NOT** serve as the waiver/opt-out form

FOR USE BY STUDENT HEALTH SERVICES ONLY

Insurance Company Name: _____

Address _____
Street
City
State
Zip

Telephone: (____) _____

Policy Holder Name: _____

ID Number: _____ Group Number: _____