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:

<table>
<thead>
<tr>
<th>Semester</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Semester</td>
<td>June 1</td>
</tr>
<tr>
<td>Spring Semester</td>
<td>December 1</td>
</tr>
</tbody>
</table>

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 Medicat 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____________________
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 (______)_______________________
MEDICAL HISTORY AND DOCUMENTATION OF NEED FOR SPECIAL ACCOMMODATION

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).

<table>
<thead>
<tr>
<th>Date Placed</th>
<th>Date Read</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 (____)_____________________

Morehouse College: Pre-Entrance Health Record 2019-2020
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)

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE MM/DD/YYYY</th>
<th>DATE MM/DD/YYYY</th>
<th>DATE MM/DD/YYYY</th>
<th>HISTORY</th>
<th>DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
<td>Type Series: □ 2 Dose Series □ 3 Dose Series / /</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>Meningococcal ACWY4,5</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>MCV4 Booster</td>
<td>/ /</td>
</tr>
<tr>
<td>(MVC4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>Meningococcal B</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
<td>(or history of Varicella) / /</td>
</tr>
<tr>
<td>Varicella</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>Tetanus-Diphtheria</td>
<td>/ / Tdap</td>
<td>/ / Td Booster</td>
<td>/ /</td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>Pertussis (Whooping Cough)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
<tr>
<td>Hepatitis B2</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
<td>/ /</td>
</tr>
</tbody>
</table>

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: _________________________
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.

☐ Reduce Pain
☐ Increase Strength
☐ Increase Function
☐ Return to Full Activity
☐ Improve Posture
☐ Prevent Surgery
☐ Improve Flexibility
☐ Prepare for Surgery
☐ Increase Cardiovascular Endurance
☐ Gain Weight: ______ lbs
☐ Lose Weight: ______ lbs
☐ 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 ______
Six (6) to seven (7) hours ______
Four (4) to five (5) hours ______
More than seven (7) hours ______

Do you struggle to say awake in the daytime? ______ Yes ______ No
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:______________________________