Morehouse College: Grades 6-12 Program Participation Health Record

Program Name _____

Program Contact: Name_____ **Number**_____

PART I

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

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

NAME_____
Last **First** **MI**

PERMANENT HOMEADDRESS_____

_____
City **State** **Zip** **Country**

SSN #_____ **HOME PHONE**_____ **CELL PHONE**_____

EMAIL ADDRESS_____

DATE OF BIRTH_____ **AGE**_____ **MOREHOUSE ID#**_____

ENROLLMENT DATE **Start date** _____ **End Date**_____

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. I have no expectation for Morehouse College to pay medical expenses for the student should he need treatment. 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 of a major illness or injury immediately.

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_____

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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 ( )_____

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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*	_____	_____	_____

mm induration (horizontal diameter) Note: *If greater than 10mm induration, chest X-ray required*
If positive, provide_____
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

PCR Date:_____ (*Must be 3-5 days prior to arrival to program to participate face –to –face)*

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 ( )_____

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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: □ 2 Dose Series □ 3 Dose Series	/ /
Meningococcal ACWY[4,5] (MCV4)	/ /	/ / MCV4 Booster[6]			
Meningococcal B[6]	/ /	/ /	/ /	Type Series: □ 2 Dose Series □ 3 Dose Series	
Varicella[2]	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough)[3]	/ / Tdap	/ / Td Booster[3]			
Hepatitis B[2]	/ /	/ /	/ /	Type Series: □ 2 Dose Series □ 3 Dose Series	/ /
Covid	/ /	/ /	Vaccine Given: □ Pfizer □ Moderna □ Johnson &Johnson	Type Series: □ 1 Dose Series □ 2 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:_____