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

Return To:
Student Health Services
Brazeal Hall Box 140064
Morehouse College
830 Westview Dr. SW
Atlanta, Georgia 30314
(470) 639-0603

The Summer Academy Health Record is required before you are allowed to move in to campus housing or participate in a Morehouse College summer program. The participant, parent/guardian, and your doctor must complete this Health Record.

- Incomplete pages and responses will result in non-participation. Please make copies of the completed Health Record for your records and mail the original to the address above.
PART I

Student/Parent Authorization to Treat and Emergency Information
Clearance to move in to campus housing will not be granted until all pre-entrance health requirements have been met.

NAME ____________________________ Last __________ First __________ MI __________

PERMANENT HOME ADDRESS ________________________________________________________________

City ____________________________ State __________ Zip __________ Country __________

SSN # ____________________________ HOME PHONE ____________________________ CELL PHONE ____________________________

EMAIL ADDRESS ____________________________

DATE OF BIRTH ____________________________ AGE ____________________________ MOREHOUSE ID# __________

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 absorb 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  ☐ Sulfamethoxazole  ☐ 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 ________

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**Physician Signature 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 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.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

MEDICAL INSURANCE INFORMATION

Insurance Company Name:  ______________________________________________________

Address_______________________________________________________________________

Street  City  State  Zip

Telephone: (____)______________  Policy Holder Name: _______________________________

ID Number:____________________  Group Number:___________________
CERTIFICATE OF IMMUNIZATION
Retain a copy of the completed form for your records.

STUDENT INFORMATION

Name: (Last) ___________________________ (First) ___________________________ (Middle) ___________________________
Address: __________________________________________ City: ___________________________ State: _______ Zip: __________

Year of Application: ______________________ Age at time of application: _______ Date of Birth (mm/dd/yyyy): ___/___/_____

REQUIRED IMMUNIZATION INFORMATION

<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&lt;sup&gt;1&lt;/sup&gt;</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;2&lt;/sup&gt;</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>Type Series:</td>
<td>□ 2 Dose Series □ 3 Dose Series / /</td>
</tr>
<tr>
<td>Meningococcal ACWY&lt;sup&gt;4,5&lt;/sup&gt; (MCV4)</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>MCV4 Booster&lt;sup&gt;6&lt;/sup&gt;</td>
<td>/ /</td>
</tr>
<tr>
<td>Meningococcal B&lt;sup&gt;6&lt;/sup&gt;</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>Type Series:</td>
<td>□ 2 Dose Series □ 3 Dose Series / /</td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;2&lt;/sup&gt;</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>(or history of Varicella)</td>
<td>/ /</td>
</tr>
<tr>
<td>Tetanus-Diphtheria Pertussis (Whooping Cough)&lt;sup&gt;3&lt;/sup&gt;</td>
<td>/ / Tdap</td>
<td>/ / Td Booster&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td>Type Series:</td>
<td>□ 2 Dose Series □ 3 Dose Series / /</td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;2&lt;/sup&gt;</td>
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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. 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>___________________________</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. 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: X-Ray results: □ Normal □ Abnormal

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: ___________________________ Signature: ___________________________
Address: __________________________________________
Date of Issue: _______ / _____ / _______ Telephone: ___________________________
Waiver, Release and Indemnification

We the undersigned request that ____________________ ("Participant") be granted permission to participate in ______________________, to be held at Morehouse College from _________________, to _________________, ("Activity").

In consideration of the Participant’s being permitted to participate in the Activity, we do release, waive, forever discharge and covenant not to sue Morehouse College, its governing board, officers, agents, employees and any students acting as employees ("Releases"), from and against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs, and expenses of any nature which Participant or his or her Parent or Guardian, arising out of or related to any loss, damage or injury, that may be sustained by Participant or by any property belonging to Participant or his or her Parent or Guardian, whether caused by the negligence or carelessness of the Releases, or otherwise while Participant is in, on, upon or in transit to or from the premises where the Activity, or any adjunct to the Activity, occurs or is being conducted.

We further state that there are no health-related reasons or problems which precludes or restrict Participant's participation in this Activity, and that Participant has or will have adequate health insurance necessary to provide for and pay any medical costs that may be attendant as a result of any injury to the Participant.

It is our express intent that this Waiver, Release and Indemnification Agreement shall bind the members of Participant’s family and spouse if married. Participant and/or Participant’s parent/guardian further agree to save and hold harmless, indemnify and defend the Releases from any claim by Participant’s family arising out of Participant’s participation in this Activity.

Participant further agrees to abide by the rules and regulations of the College while participating in this Activity and acknowledges and recognizes the right of Morehouse College, through its employees or agent, to terminate his or her participation in this Activity should (s)he not abide by the stated regulations. Participant agrees to supply a signed copy of this document to his or her parent or guardian.

We further agree that this release shall be construed in accordance with the laws of the State of Georgia. If any term or provision of this Release shall be held illegal, unenforceable or in conflict with any law governing this Release, the validity of the remaining portions shall not be affected.

I, Participant’s Parent/Guardian further state that I am the Participant’s Parent/Guardian, and am fully competent to sign this Agreement, and that I execute this release for full, adequate and complete consideration of my own free act and deed, fully intending for myself, for the Participant and for the Participant’s family, estate, heirs, personal representative or assigns to be bound by the same. No oral representation, statements, or inducements, apart from the foregoing have been made.

THIS IS A RELEASE OF LEGAL RIGHTS, READ BEFORE SIGNING.

_______________________________________________
Parent/Guardian (Signature) Date

______________________________
Witness (Signature)

_______________________________________________
Address

_______________________________________________
Student/Participant (Signature) Witness (Signature)

No student will be allowed to participate in the Summer Academy Program unless this form has been received prior to or upon arrival, or otherwise designated by the Program Director. If you have not already done so, please return the form to the Director of the Program in which you will participate.