JACKSONVILLE STATE UNIVERSITY
Jacksonville, Alabama

The Medical Record Form becomes a part of the permanent confidential JSU STUDENT HEALTH CENTER RECORD. It serves as the basis for decisions concerning activities at the University in which health status is involved and as a background for treatment by University physicians. Information from the health information form may not be released to a third party unless an acceptable authorization in compliance with State and Federal Regulations is furnished to the SHC.

MAIL TO: Director of Student Health Services Student Health Center
Jacksonville State University
Jacksonville, Alabama 36265

or FAX TO: 256-782-5307

Please complete this form by printing in ink legibly or typing.

NAME: _____
Last First Middle

PERMANENT HOME ADDRESS: _____
Street or P.0.B.#

_____
City State Zip

D.O.B. _____ M ___ F ___ SS# _____ Marital Status _____
Mo./Day/Year Single, Divorced, Married

Name of Parents, Guardian, Spouse (Circle one):

_____
Name

_____
Street

_____
City State Zip

Telephone# ( ) _____

STATEMENT AND SIGNATURE BY APPLICANT AND PARENT OR GUARDIAN

All statements in this form are true to my knowledge and I have no abnormality, limitation, or restriction not mentioned in this record. I understand that this form is a part of my official application to the University. I agree to notify the Student Health Center of any change that occurs in my physical or mental health either prior to my registration or while I am a student at JSU. I give permission for such diagnostic, therapeutic and operative procedures as may be deemed necessary.

Date _____ Signed _____
Signature of Applicant

I give permission for such diagnostic, therapeutic and operative procedures as may be deemed necessary for my son/ daughter. (Where practical you will be notified by telephone before any procedures are done.) Parental signature is not required if the student is nineteen (19) years of age or older.

Date _____ Signed _____
Signature of Parent or Guardian

Under the Family Educational and Privacy Rights Act of 1974, medical records may be disclosed only to a physician or other appropriate professional of the student's choice, or pursuant to court order or other legal process.

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Address: _____ _____
Street City State Zip

Telephone #- ( ) _____ Applicant's Signature: _____

MEDICAL INSURANCE INFORMATION

COMPANY _____

NAME OF INSURED _____

CONTRACT NUMBER _____ GROUP# _____

_____ DO NOT HAVE MEDICAL INSURANCE

LIST ANY OPERATIONS AND/OR INJURIES YOU HAVE HAD AND DATES:

_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:		YES	NO
1.	Diabetes		
2.	Rheumatic Fever		
3.	Heart Problems or Disease		
4.	Asthma		
5.	Tuberculosis		
6.	Allergies (drug, food, and other, specify)		
7.	Kidney or Bladder Disease		
8.	Ulcer		
9.	High Blood Pressure		
10.	Seizure Disorder		
11.	Emotional Disorder		
12.	Orthopedic Disorder		
13.	Vision Impairment		
14.	Hearing Impairment		
15.	Speech Impairment		
16.	Cancer		
17.	Menstrual Disorder		
18.	Chicken Pox		
19.	Other (Describe)		

DETAILS OF ALL YES ANSWERS: _____

_____

LIST ALL MEDICATIONS YOU ARE TAKING AND DOSAGE: _____

_____

_____

IMMUNIZATION INFORMATION	Dates
Tetanus, Diphtheria	
Oral Polio Vaccine	
Measles	
Mumps	
Rubella	
Tuberculin Test, results	

MEASLES

*DOCUMENTATION OF MEASLES INFECTION, IMMUNITY OR VERIFICATION OF TWO DOSES OF VACCINE REQUIRED IF BORN IN OR AFTER 1957.

* PHYSICIAN SIGNATURE OR CLINIC STAMP NEEDED FOR IMMUNIZATION VERIFICATION _____

DATE _____