Grambling State University
Foster-Johnson Health Center
(318) 274-2351 (phone)
Please submit forms via fax (318) 274-2481

MEDICAL HISTORY

Students are to complete the following form carefully. All information is confidential, and reviewed by Health Center Personnel only.

Student Information (Please Print)

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

Address: _____
(Street) (City) (State) (Zip Code)

Telephone: (___) _____Cell: (_____) _____ Email address: _____

G-number: _____ Date of Birth: _____ Age: _____ Sex: _____

Entering Semester/Year _____ Are you planning on living: ____On Campus __Off Campus

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: (_____) _____ Work Phone: (_____) _____Cell Number: (_____) _____

Family History

Has any member of your family ever had any of the following? (Please Check)

___ Asthma or Hay Fever ___ Cancer ___ Convulsions/Seizures ___ Diabetes
___ Heart Disease ___ High Blood Pressure ___ Kidney Disease ___ Mental Illness
___ Rheumatism (arthritis) ___ Sickle Cell ___ Stomach, Intestinal Trouble ___ Tuberculosis

Personal History

List any surgery, serious illnesses, or allergies (food or drug): _____
List any medical conditions you are currently being treated for: _____
List any medications you take on a regular basis: _____
Do you use any of the following? (Please Check)

___ Artificial Limb or Eye ___ Braces ___ Crutches ___ Eye Glasses/Contact Lens
___ Extremity or back ___ Hearing Aid ___ Wheelchair
Comments: _____

Insurance

Type	Company	Policy	Expiration Date
Accident and Hospitalization			
Automobile			

Medical Consent

In the event of a medical emergency or life-threatening situation and in consultation with university health service physician, nurse practitioners and nurses, I hereby grant permission to authorize medical treatment or other medical care that might be deemed necessary to my health and well-being; also when necessary for executing such care, permission for hospitalization at an accredited hospital is granted. I understand that I am responsible for personal expenses not provided by the student insurance plan. This medical consent is valid as long as the above student is enrolled at Grambling State University unless cancelled in writing.

_____ _____ _____ _____
(Signature of Student) Date (Signature of Parent/Legal Guardian, if required) Date

PRINT