



MEDICAL HISTORY

(Please Print Clearly and Complete Both Sides)

! REMEMBER! YOUR CLASSES WILL BE CANCELLED IF FORM NOT COMPLETED AND RETURNED BY AUGUST 22, 2008

Name: _____
Male _____ Female _____

Permanent Address: _____
Social Security # or SID#: _____ Date of Birth: _____

ENTERING AS: (Circle one)

Citizenship: U.S. _____ Other (Specify) _____ FR SOPH JR SR LAW CC GRAD EMP

EMERGENCY CONTACT INFORMATION:

Name: _____
Relationship: _____ Telephone: Home () _____
Work () _____
Cell () _____

Health Insurance Company: _____ Policy Number: _____
Type of Coverage: _____ (PPO, HMO, etc)

Have you ever had any of the following: (check if applicable)

- | | | | |
|---|--|---|-------------------------------------|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Chronic Hay Fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Headache Chronic/Migraine | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Intestinal/Stomach/Disorder | <input type="checkbox"/> Malaria | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mono |
| <input type="checkbox"/> Menstrual Problems/Pain | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Psychological Counseling | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Loss of Consciousness/Fainting | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> TB |
| <input type="checkbox"/> Positive TB Skin Test | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Spleen Removed | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Chronic Sinus Infections | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Chronic Bladder/Urinary Infections | |

Brief Explanation of any POSITIVE Responses: _____

History of Surgery: Yes No Ongoing Medical Problems: Yes No (if yes, list below)

Environmental Allergies: _____ List Current Medications: _____
Medical Allergies: Yes No _____
(List Medication/Reaction) _____
Herbs: _____
Tobacco Use: Yes No Type: _____ Frequency of tobacco use: _____

ALL MEDICAL INFORMATION IS STRICTLY CONFIDENTIAL! **CONSENT TO MEDICAL AND/OR SURGICAL TREATMENT**

The undersigned hereby gives consent to the physician, or anyone acting under him/her, to carry out or cause to be carried out any and all emergency and/or non-emergency medical or surgical treatment, which in said physician's judgment is in the patient's best interests. Treatment may be received at any suitable location of the University or patient's choice.

Physician _____ Telephone Number _____ Hospital _____

I certify that the Medical History I have provided is accurate and complete to the best of my knowledge.

Signed by: _____, this _____ day of _____, 20____
Student's Signature

_____, this _____ day of _____, 20____
Parent or Guardian's Signature (if required)

PLEASE RETURN THIS FORM TO:

Loyola University New Orleans
Student Health Services
Box 179, 6363 St. Charles Ave.
New Orleans, La 70118
(504) 865-3326 Fax (504) 865-2393



PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning

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Name: _____ Email: _____
Social Security# or SID#: _____ Telephone: () _____

IMMUNIZATION REQUIREMENTS FOR LOYOLA UNIVERSITY NEW ORLEANS STUDENTS PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION

(A physician must complete this section or attach a signed copy of immunization to this record)

MMR (Measles, Mumps, Rubella)
(Two Doses Required)

1st Dose: _____
2nd Dose: _____

or

MEASLES (Two Doses Required)

1st Dose: _____

2nd Dose: _____

or

Date of Disease: _____

MUMPS (One Dose Required)

Date of Immunization: _____

or

Date of Disease: _____

AND

TETANUS/ DIPHTHERIA (Required within 10 years)

Date: _____

RUBELLA (One Dose Required)

Date of Immunization: _____

or

Date of Disease: _____

AND

MENINGITIS (Required)

Date: _____

PPD TB SKIN TEST/CHEST X-RAY
(Recommended not Required)

Date _____ Results _____

Please place clinic stamp above

Signature of Physician or Other Health Care Provider

Date

Address

Telephone

REQUEST FOR EXEMPTION: If you request an immunization exemption for medical or personal reasons, please check the appropriate box and provide the information requested.

Medical History & Immunization Form must be submitted with Exemption Letter

I request an exemption from MMR/Tetanus vaccinations for the following reasons:

- Medical Reasons: Provide letter from a physician
- Religious Reasons: Provide letter from pastor or clergy
- Personal Dissent: Provide waiver of vaccination from student/parent or guardian if required

I request an exemption from Meningitis vaccination for the following reasons:

- Medical Reasons: Provide letter from a physician
- Religious Reasons: Provide letter from pastor or clergy
- Personal Dissent: Provide waiver of vaccination from student/parent or guardian if required

After consulting with my physician, I am aware of my personal risk for meningitis and have chosen not to be vaccinated. I understand that this puts me a greater risk of acquiring meningitis and Loyola University is released from any liability should I contract meningitis while I am enrolled. The University may exclude from attendance all students who do not have the immunizations until the appropriate disease incubation has expired or the student presents proof immunization.

(Student's Signature) (Date)

(Parent or Guardian, if required) (Date)