

MEDICAL HISTORY

(Please Print Clearly)

Next of Kin for Emergency Notification (Relationship)

Home Telephone Number

Health Insurance Company

Policy Number

Type of Coverage

REPORT OF MEDICAL HISTORY

PHYSICIAN - Specify name of family physician, if any.

Telephone Number

Fax Number

ALLERGIES: Drug allergies: _____

Other: _____

Comment below on all "Yes" answers. Have you ever had any of the following?

Yes	No	Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles(Red)	Hay Fever	Chest Pain/Pressure	Jaundice				
German Measles	Asthma	Chronic Cough	Mononucleosis				
Mumps	Appendectomy	Palpitation (Heart)	Gallbladder Trouble				
Chicken Pox	Tonsillectomy	Rheumatic Fever	Stomach Ulcers				
Malaria	Hernia Repair	High Blood Pressure	Recurrent Diarrhea				
Anemia	Other Surgery	Heart Murmur	Recent Weight loss/gain				
Gum/tooth Trouble	(note below)	Heart Disease	Dizziness/Fainting				
Sinusitis	Insomnia	Joint Disease/Injury	Weakness/Paralysis				
Eye Problems	Recurrent Headache	Arthritis	Venereal Disease				
Ear Problems	Recurrent Bladder	Back Problems	Diabetes				
Recurrent Colds	Infection	Tuberculosis	Hypoglycemia				
Tumor, Cancer, Cyst	Kidney Disease	Seizure/Convulsions	Other Infectious				
Shortness of Breath	Head Injury	Unconsciousness	Diseases				

Remarks or additional information on all "YES" answers and Drug Allergies.

List all medication(s) currently taking.

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

(Signature of Parent or Guardian if student enters Loyola as a minor, or less than 18 years of age)



PROOF IMMUNIZATION COMPLIANCE
(Louisiana R.S. 17:170 School of Higher Learning)

Please complete both sides of this form carefully. Information given will become part of your health record. All health records are confidential.

Name: _____
(Last) (First) (M.I.)

Permanent Address: _____
(City/State/Zip)

Telephone Number: _____ Social Security Number _____

Entering (circle one): FR SO JR SR GRAD LAW MBA City College

Date of Birth: _____ M/F _____
(month/day/year)

PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION (physician must complete this section or attach signed copy of immunizations to this record) **Measles, Mumps Rubella (2 Doses) required for those born after January 1, 1957. Tetanus/diphtheria required for all students LA R.S. 17:170**

MMR (Measles, Mumps, Rubella) **(Required)**

1st Dose: _____
2nd Dose: _____

or

MEASLES **(Required)**

1st Dose: _____
2nd Dose: _____

or

Date of Disease: _____

TETANUS/ DIPHTHERIA **(Required)**

Date: _____
(within last 10 years)

MUMPS

Date of Immunization: _____

or

Date of Disease: _____

PPD TB SKIN TEST /CHEST X-RAY **(Recommended)**

Date: _____ Results _____

RUBELLA

Date of Immunization: _____

or

Date of Disease: _____

Meningitis **(Recommended)**

Date _____

(Signature of Physician or Other Health Care Provider)

(Please Place Address or Stamp Above)

REQUEST FOR EXEMPTION: (COMPLETE ONLY IF APPLICABLE)

If you request exemption for medical or religious reasons, please check the appropriate blank and provide the information requested.

1. Medical Reasons: _____ (Physician's statement: use space below)
2. Religious Reasons: _____ (State reason)

I understand that if I claim exemption for medical or religious reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps or rubella until the outbreak is over or until I submit proof of immunization. If I am not 18 years of age, my parents or legal guardian must also sign below.

(Student's Signature)

Date: _____

(Parent or Guardian, if required)

Date: _____