LOYOLA UNIVERSITY NEW ORLEANS

STUDENT MEDICAL HISTORY FORM

(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	
__	__	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 (note below)	__	__	Heart Murmur	__	__	Recent Weight loss/gain
__	__	Gum/tooth Trouble				__	__	Heart Disease	__	__	Dizziness/Fainting
__	__	Sinusitis	__	__	Insomnia	__	__	Joint Disease/Injury	__	__	Weakness/Paralysis
__	__	Eye Problems	__	__	Recurrent Headache	__	__	Arthritis	__	__	Venereal Disease
__	__	Ear Problems	__	__	Recurrent Bladder Infection	__	__	Back Problems	__	__	Diabetes
__	__	Recurrent Colds				__	__	Tuberculosis	__	__	Hypoglycemia
__	__	Tumor, Cancer, Cyst	__	__	Kidney Disease	__	__	Seizure/Convulsions Unconsciousness	__	__	Other Infectious Diseases
__	__	Shortness of Breath	__	__	Head Injury						

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**:**_______________________

MUMPS

Date of Immunization:__________________

or

Date of Disease: ______________________

RUBELLA

Date of Immunization: ________________

or

Date of Disease**:** ___________________

TETANUS/ DIPHTHERIA (Required)

Date: ______________________

(within last 10 years)

PPD TB SKIN TEST /CHEST X-RAY

(Recommended)

Date:________________Results___________

Meningitis (Menactra 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.

____ Date: ____________________

(Student's Signature)

____ Date: ____________________

(Parent or Guardian, if required)