STUDENT HEALTH FORM

Mail or fax to:
Jacksonville State University
Student Health Center
1701 Pelham Road South
Jacksonville, Alabama 36265-1602
P.256.782.5310 F.256.782.5307

NOTICE: The information provided on the Student Health Form is strictly confidential. Information may not be released to a third party unless you provide authorized release. This authorized release must comply with State and Federal Regulations. The information contained herein is required for medical treatment at the Student Health Center. Incomplete or inaccurate information may result in inability to register for classes, cancellation of class registration, or cause improper decision/diagnosis for your future medical care.

Name: Last	First	MI	JSU ID#:_____
Address:	Gender :		SS#: _____-___-_____
City: State: Zip:			Birth date: __/__/____
Phone/Cell:			U.S. Citizen (Circle): Y N
Emergency Contact: Name:	Number:	Relationship:	
Will you be covered by a medical insurance policy while enrolled? (Circle): Y N	**Please attach a copy of your insurance card (front and back) with this form.**		

Have you ever been diagnosed with /treated for:

		Medical Condition:	Year:	Remarks:			Medical Condition:	Year:	Remarks:
Y	N	Abnomal Bleeding Tendencies			Y	N	Heart Condition/ Disease/Murmur		
Y	N	Alcohol/Drug Problems			Y	N	High Blood Pressure		
Y	N	Anxiety/Panic Attacks			Y	N	Kidney/Bladder Disease		
Y	N	Asthma			Y	N	Liver Disease		
Y	N	Attention Deficit/Hyperactivity Disorder/Learning Disability			Y	N	Mononucleosis		
Y	N	Cancer			Y	N	Rheumatic Fever		
Y	N	Chickenpox			Y	N	Severe Headaches		
Y	N	Cholesterol/Lipid Problems			Y	N	Severe Visual Problems		
Y	N	Depression			Y	N	Smokes 1+ pkg cig/week		
Y	N	Diabetes			Y	N	Stomach Disease		
Y	N	Diminished Hearing			Y	N	Surgery		
Y	N	Eating Disorder/ Anorexia/Bulimia			Y	N	Thyroid Disease		
Y	N	Emotional/ Psychological Problems			Y	N	Tuberculosis		
Y	N	Epilepsy/Convulsions/Seizures			Y	N	Ulcer		
Y	N	Fractures/Broken Bones			Y	N	Other (Specify)		

Allergies (Drug, Food, Environmental):		
Current Medications (Prescriptive and Over-the-Counter):		
Have you been treated for any MAJOR medical or emotional problems within the past 5 years? (If yes, explain):	Y	N
I have a disability, and I authorize the Student Health Center to share this information with the office of Disability Support Services.	Y	N
I have a need for counseling services, and I authorize the Student Health Center to share this information with Counseling Services.	Y	N
I certify I have reviewed the Student Health Center Privacy Notice (available at www.jsu.edu/studenthealth).	Y	N

I certify the information given on this form is true and correct, and I have no abnormality, limitation, or restriction not mentioned on this form. I understand this form is 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 the University. Further, I give my permission for any diagnostic treatment/procedures as may be deemed necessary. I acknowledge by my signature that I have read and understand these statements.

_____ _____ _____

Signature *Date* *Printed Name*