GEORGETOWN COLLEGE

Student Health Center

# MEDICAL QUESTIONNAIRE

*Please read other side before completing this form*

## Student Information

Name: ______________________________ Date of Birth: ______________

*(Last)* *(First)* *(Middle)*

Height: __________ Weight: __________ Sex at Birth: Male _____ Female _____ Preferred Pronoun: __________

Home Address: ____________________________________________

*(Street)* *(City)* *(State/Province)* *(Zip/Postal Code)* *(Country)*

Cell Phone: ______________

Emergency Contact Name: ______________ Emergency Contact Cell: ______________

## Medical Services

Primary Care Physician: ______________ Telephone: ______________

*I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at GC and that the college will not be responsible for any medical expense acquired outside of Our Medical Clinic or testing ordered by the Student Health Center that can not be performed at the Clinic. I am currently covered under the following insurance policy. I understand I must provide a photocopy of my ID card in the event Health Services refers me to an outside provider. However, I understand that if I do not have Health insurance, I am fully responsible for my medical testing performed outside of the clinic.*

Signature ____________________________________________

Health Insurance: ____________________________________________

*(Company, Member ID or Policy ID #, Group #,)* *(Please include a photocopy of your insurance ID)*

## Medical Information

Past Medical History, including Chronic Medical Problem(s): ______________

____________________________________________

Past Surgical History: ______________

____________________________________________

List all prescription and over-the-counter medications you are taking:

| Medication | Dosage & Frequency | Medication | Dosage & Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Medication Allergies: ______________ Environmental Allergies: ______________

Family History of Significant Illnesses: ______________

## Vaccination Record

*For the protection of all students, Georgetown College requires all student living in campus housing to provide proof of the following vaccines. Please provide a copy of immunization records prior to the first day of classbefore the semester that you will be entering.*

Meningitis (A,C,W,Y) Date Received ________ Polio Date Received ________

Meningitis (B) Date Received ________ Varicella Date Received ________

MMR Date Received ________ TB Test Date Received ________ POS/NEG *(within past 6 months of move in)*

Tdap Date Received ________ COVID Vaccine Date Received ________ *(Please provide copy of card)*

Signature ______________________________ Date: ______________

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## Directions

On the other side of this form, you will be asked a series of questions relating to your medical history. Please print or type the information requested. Complete all items. Do NOT leave blank spaces. If the item does not apply, print N/A for not applicable. Upon completion, please sign and date the form, and mail it along with your other health forms to Georgetown College Student Health Center, Attn: Kelli Thompson, 400 East College Street, Georgetown, Kentucky 40324.

## Confidentiality

This medical questionnaire is required from all Georgetown College students. Your information will be kept confidential, according to certain legal and ethical guidelines such as the Health Insurance Portability and Accountability Act (HIPAA). Your information will be available only to Student Health Services staff, supervisory medical staff of the Baptist Health Medical Group and to persons you designate in writing with a signed release form. You can be provided a notice of confidentiality and privacy practices when you visit Student Health Services for your first visit.

## Mission of the Student Health Center

*The staff of the Student Health Center are concerned with the good health of all students. In a college situation the good health of an individual is essential to excellence in performance and college community harmony.*

**Please also sign below, signifying that you give permission for the staff of Student Health Center to contact appropriate persons on campus to alert them to your condition if necessary to take you out of classes due to a contagious illness or housekeeping to enable appropriate disinfection of your room if necessary.**

***My signature below indicates that I give permission to Student Health Center staff to communicate with other college staff, as needed, to arrange housing, classrooms, and/or accommodations based on my diagnosed health condition(s).***

**Signature** ______________________________ **Date:** ______________

## Permission for Treatment if Student is Less than 18 years of Age

If you are less than 18 years of age, you will need to have a parent or legal guardian give permission for evaluation and treatment. Please have the person print your name and sign below.

**I give permission for** ______________________________ **to be evaluated and treated at the Georgetown College Student Health Center.**

**Parent or Guardian's Signature:** ______________________________ **Date:** ______________