SHAW UNIVERSITY STUDENT HEALTH SERVICE

118 East South Street
Raleigh, North Carolina 27601
Phone: 919-546-8286 or 919-719-6324; Fax: 919-883-9496
www.shawu.edu/StudentHealthCenter

REPORT OF MEDICAL HISTORY:

(To be completed by student / parent, for review by physician)

Shaw ID # _____

Gender _____

_____/_____/_____

Last Name (print) **First Name** **Middle Initial** **Date of Birth** **Social Security Number**

HOME ADDRESS (NUMBER & STREET **CITY** **STATE** **ZIP** **CELL #** **HOME #**

☐Fr. ☐Soph. ☐Jr. ☐Sr. ☐Grad ☐Yes (Date: _____) ☐No ☐ Fall ☐Winter ☐ Spring ☐ Summer 20_____

CLASS YOU ARE ENTERING (Check) **PREVIOUSLY ENROLLED HERE** **PROPOSED DATE OF REGISTRATION**

HEALTH INSURANCE: NAME OF COMPANY **ADDRESS** **POLICY NUMBER**

In case of Emergency Notify: **NAME** **RELATIONSHIP**

Cell # **Home #** **Other #**

PARENTS OF STUDENTS UNDER 18: I hereby authorize any medical treatment for my son / daughter which may be advised or recommended by the physicians of Shaw University Student Health Services.

Signature of Parent / Guardian Date

FAMILY HISTORY	YES	NO	Relationship
Asthma, Hay Fever	☐	☐	
Autoimmune Disease	☐	☐	
Cancer (Specify)	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
Hypertension	☐	☐	
Psychiatric Disorder	☐	☐	
Seizure Disorder	☐	☐	
Stomach Disorder	☐	☐	
Sudden Death, cause unknown, before age 50	☐	☐	

PERSONAL HISTORY: Please comment on all yes answers in the comment section or on an additional sheet.

HAVE YOU HAD / HAVE:	Y	N	COMMENTS / ADDITIONAL INFORMATION
Any disease or condition that is being followed by a physician for treatment, which should be continued or periodically evaluated? (Give details)	☐	☐	
Have any drug allergies or other known sensitivity or intolerance? (Give details and treatment.)	☐	☐	
Any illness, injury, operation or been hospitalized other than as already noted above? (Give details)	☐	☐	
Your physical activity been restricted during the last five years? (Give reasons and duration.)	☐	☐	
Ever been hospitalized for mental or emotional illness? (Give name(s) phone number, and address of doctors and /or hospital addresses.	☐	☐	
Ever had to interrupt school or work either because of mental or emotional illness or after psychiatric consultation? Give details and doctors(s) names(s) phone number and addresses.	☐	☐	

STATEMENT BY STUDENT / PARENT: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I hereby give my permission to any doctor, hospital, or other medical agency to release confidentially to the Shaw University Student Health Physician(s) any information you may have concerning my medical condition and your professional contact with me.

Signature of Student / Parent Date Physicians Signature (Acknowledging Review) Date

PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICAN: Please review the student's history, complete the physical examination form, and comment on all positive answers. The information supplied will be used only as a background for providing health care, if necessary. It is strictly for the use of the Student Health Service and will not be released without the student's consent. Please include any laboratory diagnostic exams that are medical history appropriate.

_____/_____/_____

Last Name **First Name** **Middle Initial** **Date of Birth** **Social Security Number**

Height_____ Weight_____ B.P._____/_____ Pulse_____/min

Contact Lenses: ☐Y ☐N	**Vision**:	**Hearing (gross)**	**LMP Date:**
Glasses: ☐Y ☐N	Corrected: R 20/ L 20/	Right: Pass Fail	Regular ☐Y ☐ N
	Uncorrected: R 20/ L 20/	Left: Pass Fail	How many in a year?

Medication Allergies: **Food Allergies:**

Are there abnormalities of the following systems? **Describe if yes, use additional sheet if necessary**

	YES	NO	
Head, Ears, Nose, Throat	☐	☐	
Eyes	☐	☐	
Respiratory	☐	☐	
Cardiovascular	☐	☐	
Gastrointestinal	☐	☐	
Hernia	☐	☐	
Genitourinary	☐	☐	
Musculoskeletal	☐	☐	
Metabolic/Endocrine	☐	☐	
Neuropsychiatric	☐	☐	
Skin	☐	☐	
Hands / Feet	☐	☐	
Mammary	☐	☐	

Is there loss or seriously impaired function of any paired organ? Yes☐ No☐ If yes, explain:_____

Do you have any recommendations regarding the care of this student? Yes☐ No☐ If yes, explain:_____

Is this student now under treatment for any medical or emotional condition? Yes☐ No☐ If yes, explain: _____

REQUIRED: Recommendations for physical activity for Phys. Ed., Intramurals, Intercollegiate, General education requirements.
☐Unlimited ☐Limited ☐No PE. Explain if limited or no PE:_____

_____

Signature of Physician/ Physician Assistant/ Certified Nurse Practitioner

Date _____

OFFICE/CLINIC STAMP WITH ADDRESS AND TELEPHONE NUMBER

Tuberculin Skin Test (within one year)

Date applied_____ Date read _____ by _____
Positive _____mm Negative_____
Chest x-ray if positive skin test Date _____ Attach results

NORTH CAROLINA STATE LAW REQUIRES ALL NEW AND TRANSFER ENROLLEES PROVIDE PROOF OF UPDATED IMMUNIZATIONS: Please attach immunization record from high school, doctor's office, or local Health Department.

If student plans to participate in intercollegiate sports, you must provide a sickle cell screen blood test. Please attach results of sickle cell lab test to physical form. Mail all medical information to: **Shaw University Student Health Services, 118 East South Street, Raleigh, North Carolina, 27601.**