

**CONFIDENTIAL**

**HAMPTON UNIVERSITY**  
HEALTH CENTER  
Hampton, VA 23668  
(757) 727-5315

**CONFIDENTIAL**

**MEDICAL RECORD**

**DEADLINE JUNE 1 (FALL SEMESTER) AND DECEMBER 1 (SPRING SEMESTER) OF THE CURRENT ENROLLMENT YEAR**

**PART I**

1. NAME LAST FIRST MIDDLE			2. DATE	3. SEX
4. HOME ADDRESS CITY STATE ZIP			5. DATE OF BIRTH	6. SOCIAL SECURITY NO.
7. HAMPTON UNIVERSITY ID NO.	8. NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN			9. TELEPHONE NO.
10. FAMILY PHYSICIAN - NAME AND ADDRESS				

**PART II**

**School Status:**  Undergraduate  Graduate  Division of Continuing Studies  College of Va. Beach

**PARENTAL PERMIT**

The law requires that parental permission be obtained for procedures on minors. In order for a minor to be treated by the Health Center, the following consent form should be signed by the parent or legal guardian so that such treatment may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except in an extreme emergency, without the parents being contacted and fully informed!

I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son / daughter (*cross out one*).

Signed \_\_\_\_\_

Relationship \_\_\_\_\_

I do / do not (*cross out one*) carry hospitalization, sickness and accident insurance for my son / daughter. \*

Insurance Company or Agent \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Company Address \_\_\_\_\_

ID/Group Policy Number \_\_\_\_\_

\* If you do not have proper insurance for the above named applicant, the college will provide insurance and add the premium to the college bill unless you specifically state otherwise.

Do you have any chronic diseases? If so, please list: \_\_\_\_\_

Do you take any medications daily? If so, please list: \_\_\_\_\_

11. Indicate any of the following complaints you have had with any frequency (*Please check*):

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Backache         | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Night Sweats     | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Fainting Spells  | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Skin Trouble        |

12. Give any special details that you consider important concerning treatment and recovery in connection with the diseases and complaints checked under Question No. 11. \_\_\_\_\_

13. Please describe any prior or current treatment by a mental health provider such as psychiatrist, psychologist or counselor: \_\_\_\_\_

14. Do you have any food or medication allergies? If so, please explain: \_\_\_\_\_

**IMPORTANT: The University requires each student to take physical education.**

15. Do you have any physical defects, deformities or other conditions which limit your physical activities? If so, please specify: \_\_\_\_\_

16. Do you require the use of a wheelchair, crutches, or other ambulatory aids? If so, please specify: \_\_\_\_\_

I certify that the foregoing statements are true to the best of my knowledge. I realize that falsification of the provided information is a violation of the University Code of Conduct and could result in sanctioning by a hearing panel.

Date \_\_\_\_\_

Signature \_\_\_\_\_



