

# Southern Virginia University

## Student Health History

### To the Student/Parent:

If you need more room to answer any question, please attach an additional sheet of paper. All information recorded will be held in the strictest confidence. Only authorized personnel will have access to the information.

**Please include** the following with this form:

1. A copy of your health insurance card (**front and back, no handwritten copies please**) or signed Health Insurance Waiver Form. Please be aware that the University will not be responsible for payment for any student's injury, accident, or illness; unless the University is shown to be negligent. This includes co-pays, deductibles or other expenses related to the medical condition that are not covered by the students insurance. **(Athletes are required to have current health insurance in order to participate).**

### Emergency Authorization:

We give permission to authorized personnel selected by SVU, on our behalf, to secure treatment for and/or to hospitalize the student ("emergency medical treatment") in the event of an emergency – including, on the recommendation of a physician, injections and/or anesthesia and/or surgery. We give permission for the emergency contacts listed, to be notified regarding the emergency and the treatment arranged. We agree to be responsible for all costs associated with any such medical treatment, and authorize SVU personnel to approve such medical treatment on our behalf. This form may be duplicated and given to authorized personnel. Your signature below indicates that the information that you have given is accurate and complete.

**SIGNATURE OF STUDENT:**

**Student ID #** \_\_\_\_\_

\_\_\_\_\_  
DATE: \_\_\_\_\_

Print Name \_\_\_\_\_

First

Middle

Last

Will you have a cell phone while on campus? If so, the number \_\_\_\_\_

**SIGNATURE OF PARENT/GUARDIAN/SPOUSE (if student is unable to sign):**

\_\_\_\_\_  
DATE: \_\_\_\_\_

Print Name \_\_\_\_\_

First

Middle

Last

### **Next of Kin/ Emergency Contact \*REQUIRED**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell Phone \_\_\_\_\_ Parent's e-mail address \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

## Student Health History

Print Name \_\_\_\_\_ Student ID # \_\_\_\_\_  
                    First                                      Middle                                      Last

E-mail Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Do you plan on being on a sport's team? Which one? \_\_\_\_\_

**Current Health Information**

Height \_\_\_\_\_ Weight \_\_\_\_\_ male \_\_\_\_\_ female \_\_\_\_\_ Do you wear contact lenses? \_\_\_\_\_

Do you smoke? no \_\_\_yes\_\_\_ Do you use alcoholic beverages? no \_\_\_yes\_\_\_

Date of last Tetnus immunization \_\_\_\_\_

List all medications that you are currently taking, dosage, how often you take it, and for what purpose. Use the back of this form if necessary.

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Do you have any physical limitations? Please explain \_\_\_\_\_

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Family History: Do any members of your family have a serious medical problem? Please explain:

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If you have had any of the below, please circle and provide **full** details below, attach additional paper if needed.

Allergic reactions?	Stomach or bowel problem?	Cancer?
Serious injury?	Diabetes ?	Hearing problem?
Eating disorder?	Epilepsy?	Hormonal problem?
Mental health problem?	Heart problem?	Eye problems?
Learning disability?	Liver disease?	Menstrual Disorders?
Asthma?	Kidney Disease?	Surgical Procedures?
Bleeding disorder?	Thyroid disease?	Any other not mentioned?

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Please send to:  
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One University Hill Drive  
Buena Vista, VA 24416  
Fax 1-540-266-3806