

To the Student: This form MUST be completed. Information you provide will be used as an aid to providing necessary care while you are a student. The form will not affect admission decisions but must be filled out completely and mailed to Student Health Services, North Georgia College & State University, Dahlonega, Georgia 30597. This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and written consent.

NORTH GEORGIA COLLEGE & STATE UNIVERSITY – MEDICAL REPORT

LIST THREE TELEPHONE NUMBERS TO CALL IN THE EVENT OF AN EMERGENCY:

Date of Expected Entry _____
Resident Student _____
Military Student _____
Commuting Student _____

1. _____
2. _____
3. _____
4. _____

NAME _____ / _____ / _____
(LAST) (FIRST) (MIDDLE) (SOCIAL SECURITY NO.)

HOME ADDRESS _____ HOME PHONE NO. (_____) _____

(CITY) (STATE) (ZIP CODE)

Date of exam _____ Sex _____ Marital Status _____ Age _____ Date of Birth _____

SECTION A: DISEASE AND MEDICAL HISTORY (to be completed by applicant)

Have you had or do you have:

YES / NO		YES / NO		YES / NO	
_____/____	Rheumatic Fever	_____/____	Stomach, Liver or Intestinal Disease	_____/____	Allergies
_____/____	Measles	_____/____	Nervous Disorder	_____/____	Migraine Headaches
_____/____	Mumps	_____/____	Kidney Disease	_____/____	Arthritis
_____/____	Meningitis	_____/____	Diabetes	_____/____	Pneumonia
_____/____	Polio	_____/____	Skin Disease	_____/____	Heart Condition
_____/____	Tuberculosis	_____/____	Ear, Nose or Throat Problems	_____/____	Irregular Heartbeat

Have you ever been hospitalized? _____ If "yes," when, where and why? _____

Have you ever received psychiatric/psychological treatment? _____ If "yes," when, where and why? _____

Are you taking medication for this treatment? _____ If "yes," list medication _____

Do you have epilepsy? _____ If "yes," list date of your last seizure _____ List medications for this _____

Do you have asthma? _____ If "yes," list date of your last attack _____ List medications for this _____

Have you had any fractured bones? If "yes," please explain _____

Do you have any joint problems, such as: shoulders, elbows, wrists, hips, knees, feet? _____ If "yes," please explain _____

Do you have migraine headaches? _____ If "yes," list date of last headache _____ List medications for this _____

Have you had any past surgeries? _____ If "yes," please explain _____

Do you have any history of injury to neck? _____ Chest? _____ Back? _____ Head? _____ If "yes," please explain _____

Are you taking any medication? _____ If "yes," please explain _____

Are you allergic to bee stings? _____ If "yes," do you use an epi-pen? _____

Are you allergic to any medications? _____ If "yes," please list _____

Do you have any physical or mental limitations that you are aware of? _____ If "yes," please list _____

**SECTION B: PHYSICAL EXAMINATION (To be completed by Physician)
Mandatory for all Military Students (Optional for Others)**

Height _____ Weight _____ Blood Pressure _____ Pulse _____

List any problems or observations on any of the following areas:

Throat & Tonsils	Lungs
Heart	Genito-Urinary System
Abdomen (pains, scars, masses)	Hemorrhoids
Hernia	Congenital Abnormalities
Psychiatric History (if any)	Others

Remarks continued: _____

I have examined the person whose name appears on the reverse side of this form pending his/her enrollment at North Georgia College & State University, and find him/her:

- () Qualified for unrestricted exercise (may include push-ups, sit-ups and running)
- () Qualified for restricted exercise only (explain/specify below)
- () Qualified for absolutely no physical exercise (explain below)

List any conditions that would limit this student's participation in physical activities (i.e., recent surgery or illness, chronic health problems such as trick knees or asthma, etc.) or if restricted exercise is noted above, a letter of limitations and time limit must be attached to this form by examining M.D. _____

 EXAMINING PHYSICIAN (PLEASE PRINT) DATE

 SIGNATURE OF EXAMINING PHYSICIAN ()

 ADDRESS TELEPHONE NO.

**SECTION C: WAIVER/RELEASE
STUDENT WAIVER
(For Participants in the Military)**

I understand that the military program at North Georgia College & State University is physically strenuous and release North Georgia College & State University, its employees and staff from any liability in case of illness or injury sustained in training.

 STUDENT'S NAME (PLEASE PRINT) STUDENT'S SIGNATURE

ALL STUDENT INFORMATION RELEASE

I hereby authorize the release of medical information to officials of North Georgia College & State University from any doctor or hospital that I may utilize in case of illness or injury. I further authorize the physicians of the Student Health Services, their agents or consultants, to perform diagnostic and treatment procedures which in their judgment may become necessary while I am in attendance at North Georgia College & State University.

 STUDENT'S NAME (PLEASE PRINT) STUDENT'S SIGNATURE

**PARENTAL RELEASE
(Students Under 18 Years of Age)**

As the parent, guardian, or next of kin of _____, I give my permission for him/her to receive necessary, routine medical attention while enrolled at NGCSU.

 PARENT/GUARDIAN (PLEASE PRINT) ()

 RELATIONSHIP TELEPHONE NUMBER

 PARENT'S/GUARDIAN'S SIGNATURE

Students covered under Parent's Health Insurance should attach a copy of their insurance card to expedite treatment in the event off-campus referral is required.

**SEND OR TAKE THIS FORM TO:
NGCSU Health Services, North Georgia College & State University, Dahlonega, Georgia 30597**

If you are participating in the Corps of Cadets, a physician must complete this form within one year of the first day of class for the semester in which you are entering. If you are coming for the Summer Transition Program (STP), it must be within one year of the first day of Fall Semester. Please return this form to:

**North Georgia College & State University
Military Science Department
P.O. Box 156
Attn: ROTC Records
Dahlonge, GA 30533**

<p>MEDICAL FITNESS STATEMENT FOR ENROLLMENT IN BASIC COURSE, SENIOR ROTC FOR USE OF THIS FORM, SEE AR 145-1; THE PROPONENT AGENCY IS ODSCPER</p>	<p>DATE</p>
<p>I have examined (First name - Middle Initial- Last Name) _____ and find no medical condition or physical impairment that precludes his participation in the basic course, Army ROTC, a program not more physically strenuous than a normal college physical education program.</p>	
<p>SIGNATURE OF PHYSICIAN</p>	

DA FORM 3425-R, 1 SEP 68