

BRYANT UNIVERSITY HEALTH SERVICES

1150 Douglas Pike
Smithfield, RI 02917-1284
FAX (401) 232-6702

**COMPLETED FORM REQUIRED
FROM ALL STUDENTS PRIOR TO
MOVING ONTO CAMPUS**

**THIS COMPLETED FORM MUST BE RETURNED TO HEALTH SERVICES
BY AUGUST 15th FOR THE FALL SEMESTER OR JANUARY 16th FOR THE SPRING SEMESTER**

Name _____ ()Male ()Female
Last First Middle Initial

Student SS# _____ Date of Birth _____ Bryant Graduation Year _____

Home Address _____ EMAIL _____

City, State, Zip _____ Country _____

Home Phone _____ Cell Phone _____ FAX _____

Country of Birth _____ Number of Years Residing in United States _____

Person to be notified in emergency _____

Relationship to you _____

Telephone (home) _____ (work) _____

Address _____

City, State, Zip _____

Present Health Insurance Company _____

*** PLEASE ATTACH A COPY OF BOTH SIDES OF HEALTH INSURANCE CARD.**

Address _____

Policy # _____ Telephone # _____

Subscriber _____ Expires _____

FAMILY HISTORY: Please answer the following questions relating to your past and present medical history to the best of your ability. Whenever in doubt, clarify this history with your parents and or/physician.

	<u>Age</u>	<u>Current Health Status</u>	<u>If Deceased:</u>	<u>Age</u>	<u>Cause</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Have you ever been a patient in a hospital for any reason? () Yes () No
Hospital _____ Condition _____ Dates _____

Have you ever consulted a psychiatrist or psychologist? () Yes () No
If yes, please explain _____

IF YOU HAVE A SERIOUS MEDICAL CONDITION/DISABILITY, PLEASE COMPLETE

Bryant University Health Services would like to notify appropriate departments of your serious medical condition/disability in order to be able to respond to an emergency that might arise as a result of your health problem.

I hereby authorize Bryant University Health Services to release information of my serious health problem which is _____ to the appropriate departments.

PERSONAL HEALTH HISTORY (Completed by student)

Have you ever, or do you now have any of the following? If you answer "yes", please identify by number using the space below to give the date and the nature of the problem.

	YES		YES		YES
1. Sudden death of family member under age 40		16. Malaria		31. Tonsillectomy	
2. Eczema/allergic skin disease		17. Tuberculosis		32. Tumor/cancer	
3. Anemia		18. Mononucleosis		33. Severe depression	
4. Asthma		19. Chicken pox		34. Severe anxiety	
5. Pneumonia		20. Amenorrhea		35. Anorexia, bulimia, compulsive eater, restrictive dieter	
6. Heart murmurs, Mitral valve prolapse		21. Adrenal disease		36. Chlamydia	
7. High/low blood pressure		22. Diabetes		37. Genital warts/HPV	
8. Abdominal pain		23. Pituitary disease		38. Gonorrhea	
9. Hepatitis		24. Thyroid problem		39. Herpes	
10. Hernia		25. Back trouble		40. Ophthalmologic	
11. Ulcerative colitis, ulcer		26. Fractures		a. contacts	
12. Kidney disease, blood/protein in urine		27. Severe head injury		b. glasses	
13. Measles, Mumps, Rubella		28. Epilepsy/seizures		41. Any physical limitations?	
14. Missing or impaired organ (eye, kidney, testicle, etc.)		29. Migraines		42. Do you take medications	
15. Rheumatic fever		30. Appendectomy		43. Pregnancies	

PLEASE CHECK HERE IF NONE OF THE ABOVE APPLIES []

ALLERGIES TO:

DRUG:	DESCRIBE REACTION:	Life-threatening? Yes () No () Were you treated? Yes () No ()
FOOD:	DESCRIBE REACTION:	Life-threatening? Yes () No () Were you treated? Yes () No ()
OTHER:	DESCRIBE REACTION:	Life-threatening? Yes () No () Were you treated? Yes () No ()

WERE YOU TESTED? YES () NO () DO YOU CARRY EPIPEN? YES () NO ()

Students who have serious medical problems or demonstrated allergic reactions that could result in life-threatening situations are urged to wear medical alert jewelry.

EXPLAIN ANY "YES" ANSWERS BELOW/OVER USING IDENTIFYING NUMBER:

MEDICAL CARE AUTHORIZATION

"I the undersigned, hereby specifically authorize Bryant University Health Services and/or any authorized member of the staff, or duly affiliated consultant, to provide care in Bryant University Health Services, and for emergency treatment."

SIGNATURE

(IF UNDER 18 YEARS OF AGE, PARENTAL SIGNATURE IS ALSO REQUIRED)

Student (Date)

Parent (Date)

