



Complete Sections 1–4 on both sides of this sheet using **BLACK** ink. (**PRINT**)

Section 1: Personal Information

Last Name		First Name		Middle Name
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Cell Phone
Permanent Home Information			Notify in Case of Emergency	
Street Address			Name	Relationship
City	State	Zip	Address	
Home Phone	Parent's Cell Phone		Home Phone	Cell Phone

Section 2: Statement of Authorization

I authorize and request the Northland Health Center staff to administer appropriate care and emergency procedures as necessary or to defer to duty licensed personnel when indicated, including transfer to area hospitals. I understand that my name and reason for being treated by the Northland Health Center staff may be released to Northland's administration, faculty, and/or staff for official use and will be released for workers' compensation purposes. I also authorize Northland's Health Center staff, using their best judgment, to disclose to family members health information relevant to my care. This consent to treatment and release of information shall remain in effect as long as I am enrolled at Northland International University.

Student Signature	Date	Parent/Guardian Signature (if under eighteen)	Date
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For Office Use Only

MMR Immunity	Date of Last Td or Tdap Booster	Meningococcal Meningitis	Hepatitis B Series	Special Medical Concerns	Allergies
RN					

Last Name: _____ First Name: _____ Middle Name: _____

Section 3: Health History

Allergies: Drugs & Other Severe Adverse Reactions – Please complete all that apply and explain reaction.

Check here if you have no allergies.

Medication	Food
Insect	Environmental
Seasonal	Other
Are any life-threatening? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you carry an Epi Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please check if you have/had any of the following conditions. Check here if none apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Anxiety/depression | <input type="checkbox"/> Emotional/mental illness | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus problems (chronic) |
| <input type="checkbox"/> Bladder/kidney infection | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Malaria | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Muscular/skeletal disorder | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Seizures | _____ |

Explain any checked boxes above.

Prior Hospitalization or Surgeries – Please list dates and reasons.

Medications – (regular or as needed) – Please list all prescription and natural or over-the-counter medications.

Is there any other medical information or health concern that we should know about? Please attach any additional information to further explain your condition or concern.

Section 4: Signature

I attest that the information presented by me on this Medical History Form is true and accurate to the best of my knowledge.

Student Signature	Date	Parent/Guardian Signature (if under eighteen)	Date
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