



Division of Student Affairs and Enrollment Management

To our Prospective Lions and their Parent(s) or Guardian(s):

In order to provide effective medical care and assistance, Paine College requires that students have an updated medical history and physical examination form on file. Periodically, the College will ask students to update this information in an effort to ensure that appropriate personnel are able to provide medical answers when necessary. This information is strictly for the use of Student Health Services and will not be released to anyone without the knowledge and written consent of the student, their parents, or guardian. If you have any questions, please contact the Office of Student Affairs and Enrollment Management at 706-821-8302.

Failure to complete this form will impact enrollment at Paine College. Please answer as accurately and detailed as possible.

Completed medical history/physical examination forms should be mailed or delivered directly to:

Paine College
Office of Student Affairs and Enrollment Management
1235 15th Street
Augusta, Georgia 30901



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Part I- Personal Information

Name _____

Sex: M _____ F _____ Birth date _____ / _____ / _____ SS# _____ - _____ - _____

Home address _____
Street City State Zip Code

Home phone: (____) _____ Mobile phone: (____) _____

Parents/Guardian: Father: _____

Mother: _____

Address (If different from above) _____

In case of an emergency person to be notified:

Name: _____

Phone#: _____ Relationship: _____

Part II- Insurance Information

All students enrolled at Paine should have primary insurance. Please provide the following information.

Head of Household: _____ SS# _____

Employer Name: _____ Employer phone# _____

Insurance Co. Name: _____ ID#: _____

Insurance Co. phone#: _____ Is this student insured? Yes () No ()

Spouse: _____ SS#: _____

Insurance Co. Name: _____ ID#: _____

Insurance Co. phone#: _____ Is this student insured? Yes () No ()



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Part III- Authorization and Consent

I hereby agree that the attending physician assigned when I am or my child/ward is a student at Paine College may treat (including hospitalization, injection, operation and/or anesthesia) me or my child/ward in case of accident, injury or illness. I also agree that Paine College Division of Student Affairs and Enrollment Management may release medical information to physicians and/or insurance companies necessary for care/treatment or claim processing.

Student's Signature _____ Date _____
Parent/Guardian Signature _____ Date _____

Part IV- Medical History

A. Do you have or have ever had history of:
(If "yes" to multiple listing, please circle all that apply)

	Yes	No	Date
Tuberculosis	_____	_____	____/____/____
Heart Disease	_____	_____	____/____/____
Hypertension	_____	_____	____/____/____
Kidney/Bladder Disease	_____	_____	____/____/____
Nervous Disorder/Breakdown	_____	_____	____/____/____
Clinical Depression	_____	_____	____/____/____
Chronic Anemia	_____	_____	____/____/____
Sickle Cell Trait/Disease	_____	_____	____/____/____
Epilepsy/Seizures	_____	_____	____/____/____
Ulcers/Gastrointestinal Disorder	_____	_____	____/____/____
Crohn's Disease	_____	_____	____/____/____
Require Special Diet	_____	_____	____/____/____
Arthritis/Bursitis/Gout	_____	_____	____/____/____
Hemorrhoids	_____	_____	____/____/____
Hernia	_____	_____	____/____/____
Infection	_____	_____	____/____/____
Hearing Defect	_____	_____	____/____/____
Speech Defect	_____	_____	____/____/____
Recurring Tonsillitis/Strep Throat	_____	_____	____/____/____
Pneumonia	_____	_____	____/____/____
Asthma	_____	_____	____/____/____
Seasonal Allergies/Hay Fever	_____	_____	____/____/____
Allergic Reaction to Medication	_____	_____	____/____/____
(If yes, please list name(s) of medicine(s):	_____		
Allergic Reaction to Food	_____	_____	____/____/____
(If yes, please list name(s) of food(s):	_____		
Frequent Headaches/Migraines			
Cancer			
(If yes, please list type of cancer):	_____		
Diabetes			
(If yes, indicate dietary/medicine controlled or insulin dependent: please circle controlling method.)			
Chicken Pox			
Measles			
Physical Handicap			
(If yes, indicate special requirements:	_____		



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Part IV- Medical History (cont.)

STD: Syphilis

Gonorrhea _____ / _____ / _____

Herpes _____ / _____ / _____

Chlamydia _____ / _____ / _____

Genital Warts _____ / _____ / _____

Trichomoniasis _____ / _____ / _____

HIV/AIDS _____ / _____ / _____

Hepatitis A, B, or C _____ / _____ / _____
 (If yes, please circle type)

B. Please note: Medications are not dispensed from the Division of Student Affairs and Enrollment Management. Student must bring their own supply. Medications requiring special accommodation should be made known to the Division of Student Affairs & Enrollment Management. Any medications requiring needles or syringes must be documented below.

List Prescription medications currently used long term (Please use additional sheet(s), if necessary):

List non-prescription medications frequently used (Please use additional sheet(s), if necessary):

	No	Yes	Occasionally
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>