HEALTH HISTORY
MOREHEAD STATE UNIVERSITY

Counseling & Health Services
150 University Blvd.
Morehead, KY 40351
606-783-2055

To be completed by patient unless under the age of 18 then must be completed and signed by parent/guardian.
Completion of this report is required before treatment at the Counseling and Health Services Clinic at Morehead State University. All health information is confidential and will be placed on file in the Health Clinic. Please read carefully and answer all questions on the form. Consult your parents/guardian for complete and accurate information. You may need to consult your family health care provider or public health department for accurate immunization record.

Name_____
Last **First** **Middle**

Female___

Social Security Number_____**Date of Birth**_____/_____/_____**Age**_____ **Male**___
Month **day** **year**

Home address_____**Phone**_____
Number & Street **City** **State** **Zip**

Medical History Place an x in the appropriate yes or no column for each item listed and indicate year for each yes response. If any medical condition still exists for which a yes response was given , please give further detail at the end of the form.

CONDITION	YES	NO	YEAR	CONDITION	YES	NO	YEAR
Measles				Tuberculosis			
Mumps				Mental health (bipolar, depression, ADD, anxiety, etc.)			
Chicken Pox				Meningitis			
Mononucleosis				Seizures or convulsions			
Anemia or blood disorder				Paralysis			
Heart murmur/heart disease				Severe Headaches			
Rheumatic fever				Head injury or concussion			
High Blood Pressure				Stomach/intestinal trouble			
Clots in veins				Ulcer			
Gynecological problems				Hepatitis (yellow jaundice)			
Sexually Transmitted disease				Gallbladder disease			
Asthma				Thyroid disease			
Pneumonia				Diabetes			
Orthopedic injuries/fractures/surgeries				Bladder/kidney disease			
Cancer							

Have you had any illness, injury, or hospitalization not already noted?_____yes _____no. If yes, please explain
Have you ever had surgery?_____yes_____no. If yes, indicate date and type of operation:_____
_____

Are you allergic to any medications?_____yes_____no. If yes, indicate medications:
____penicillin_____tetracycline_____sulfa_____others (specify):

Are you presently taking any medication?_____yes_____no. If yes, list name of drug, dosage, strength, and frequency:

Do you use tobacco products?_____yes_____no

Have you had the following vaccinations? If yes, please supply dates or attach copy of immunization record from health care provider.

Immunization	YES	DATE (month/date/year)-*please list all dates*	NO
Diphtheria, Tetanus, and Pertussis (DPT)			
Td or Tdap (please specify)			
Oral Polio Vaccine			
MMR (measles, mumps, rubella)			
Chickenpox			
Hepatitis B			
Meningitis Vaccine			
Have you had a tuberculin skin test (TB skin test)?		POSITIVE NEGATIVE	
If TB skin test was positive, have you had a chest x-ray?			
Please give date and result if had chest x-ray			
If you are an international student or have lived outside of the United States, have you received BCG? (vaccine for tuberculosis)			
Have you lived in a household with anyone who has had tuberculosis? If yes, please explain			

Medical Personnel of Counseling and Health Service will review this health history. You will be notified in writing if further medical information is needed.

Please list the name of your personal health care provider as well as phone number and fax if available:

_____

By signing your name, MSU student ID number or social security number if no student ID, and date, you are certifying that all information is true and correct to the best of your knowledge. You are also consenting to examination and treatment by Morehead State University Counseling and Health Services staff and Dental staff. There may be additional consent forms required for release of information. This consent shall be continuing until revoked in writing. You are granting permission for Morehead State University Counseling and Health Services and Morehead State University Dental Services to use and disclose health information in order to carry out treatment, payment and health care operations as stated in Authorization and Notice of Medical Information Disclosure and Access.

You are also consenting for Morehead State University Counseling and Health Services and Morehead State University Dental Services to bill your insurance.

Student Signature_____**Date**_____

MSU ID/SSN_____

ADDITIONAL INFORMATION

Person to be notified at patient request in case of illness:_____

Please list name with day and evening phone numbers_____

MEDICAL CONSENT-FOR MINORS ONLY UNDER 18 YEARS OF AGE

By signing your name as parent or guardian, the student's name and student's date of birth, you are hereby consenting to having qualified medical personnel and/or dental personnel render to my son or daughter medical, dental and emergency treatment and/or surgical care, and services offered through Counseling and Health Services, as deemed necessary to his or her health and well-being. You grant permission for the hospitalization of your son or daughter when necessary for implementing proper medical care. There may be additional consent forms required for release of information. This consent shall be continuing until revoked in writing. I give permission for my child to obtain counseling services independently, without notification of parent or guardian. When expressed concerns involve danger to self or others, parent or guardian will be notified.

You also grant permission for Morehead State University Counseling and Health Services and Morehead State University Dental Services to use and disclose health information about your son/daughter in order to carry out treatment, payment and health care operations as stated in Authorization and Notice of Medical Information Disclosure and Access.

You are also granting permission for Morehead State University Counseling and Health Services and Morehead State University Dental Services to bill your insurance.

Parent/Guardian Signature_____ **Date** _____

Student Name_____ **Student Date of Birth**_____

INSURANCE/PAYMENT INFORMATION

Counseling and Health Services is doing business as a family practice clinic and dental services clinic as well as addressing minor urgent care issues. Please provide a copy of your insurance card at time of service, as it is the responsibility of the student to obtain health insurance. We now provide third party billing. In order to bill your insurance, we will also need the policy holder's name, date of birth, and last four digits of social security number. If no insurance is available, students will still be eligible to receive health care at the clinic.

If insurance is available on the student, please list. If no insurance, type N/A:

Name of insurance:_____

Group #:_____

Policy or ID #:_____

Policy Holder's Name:_____

Policy Holder's Date of Birth:_____

Last 4 Digits of Policy Holders Social Security #:_____

Policy Holder's Home Address:_____

Address and/or phone number to send claims (should be found on back of insurance card):_____

MOREHEAD STATE UNIVERSITY

Behavioral Agreement for Summer Camp Participants

As a summer camp participant at Morehead State University I agree to the following conditions:

1. To conduct myself in a reasonable manner that reflects the school or organization I am representing while at Morehead State University.
2. To comply with the following rules and regulations of summer camps at Morehead State University.
   - A. The consumption and/or possession of alcohol or being under the influence of alcohol on campus is strictly prohibited.
   - B. Tobacco use is prohibited on all University owned, leased or controlled property.
   - C. Illegal possession, use or sale of any drugs is prohibited. All medicine must be stored in properly labeled containers.
   - D. The possession and use of firearms or fireworks/explosive materials on campus is prohibited.
   - E. Visitation by members of the opposite sex is prohibited in residence halls except in lobby areas.
   - F. The act of unwarranted defacing, disfiguring, damaging, destruction, of and/or unlawful possession or use of property is prohibited.
   - G. Gambling is prohibited in residence halls.
   - H. Excessively noisy behavior is prohibited.
   - I. The threat of or commission of physical violence against any person is prohibited.
   - J. Being in or around construction areas is prohibited.
   - K. Shall be civil, considerate and respect all other groups on campus.
3. To take full financial responsibility for all property damage(s) that occur to my residence hall room and common areas in which I am staying and other Morehead State University facilities which are damaged as a result of my behavior.
4. I have read MSU's Policy PG-6 on Sexual Harassment and will adhere to it while a participant in this camp.

By signing this document I agree to the above terms and stipulations while I am a summer camp participant at Morehead State University.

Failure to abide by this contract may result in my immediate removal from Morehead State University property.

_____ _____

Participant Signature Date

As Parent and/or Legal Guardian of_____, I hereby agree to be bound by the above conditions and accept financial responsibility for any damages to University property caused by the above signed participant.

_____ _____

Parent/Legal Guardian Signature Date