



RESIDENCE LIFE HEALTH FORM

Required of all residential students

Name: _____ SSN: _____

Last _____ *First* _____ *MI* _____ *Preferred name* _____

Date of Birth: ____/____/____ Sex: F [] M []

Medical Insurance Company _____ Group No. _____

Policy No. _____ Pre-certification required? No Yes (____) _____

In Case of Emergency

Notify: _____

Name _____ *Relationship to student* _____

Home phone (with area code) _____ *Alternate phone (with area code)* _____

**TAPE
PICTURE
HERE**

Authorization and Consent:

By signature, I verify that the information provided on this form is true. I hereby agree that Samford University Student Health Services may evaluate and treat all injuries or illnesses for which help is sought as deemed necessary by duly licensed personnel, including immunizations and therapeutic procedures. In the case of a minor student (under the age of 19), this treatment may proceed without prior notification of the undersigned parent or guardian.

Date _____ Signature of Student _____

Signature of minor's parent/guardian _____

PHYSICAL EXAMINATION

Age	Wt.	Ht.	Pulse	B/P	Urinalysis (required)	Hemoglobin: (required)
					Alb: _____ Glucose: _____ Blood: _____	OR Hematocrit: _____
Contact Lenses	[] yes [] no				Visual Acuity: OD 20/_____ [] Corrected	
Glasses	[] yes [] no				OS 20/_____ [] Uncorrected	

PLEASE EXAMINE AND COMMENT ON THE FOLLOWING SYSTEMS:

	Normal	Abnormal	Remarks or additional information
Head, Eyes, Ears, Nose and Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Neuropsychiatric			
Skin			
Metabolic / Endocrine			
Organ loss or impairment			

Drug Allergies: _____ Current Medications: _____

Past Medical History: _____

Past Surgical History: _____

Is the patient currently under treatment for any medical or emotional condition? [] No [] Yes If so, please comment below.

Signature of Physician/Physician Assistant/Nurse Practitioner _____

Date of Examination _____
Must be within one year of entrance date.

Print Name of Physician/Physician Assistant/Nurse Practitioner _____

Address _____

() _____
Phone

**COMPLETE BOTH SIDES AND RETURN TO: Samford University Student Health Services
800 Lakeshore Drive • Birmingham, AL 35229**

