Kentucky Wesleyan College

Student Health Form

This physical report must be completed by resident and commuter students and returned to Kentucky Wesleyan College before you will be allowed to pre-register or register. **This form must be completed in its entirety.**

Student's Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Race: _____ Marital Status (circle): Single Married Divorced

Date of Birth: _____ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number: _____

Emergency Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Phone: _____

Health History

Please check if you have had any issues with the following:

☐ Arthritis	☐ Epilepsy	☐ Lungs	☐ Stomach
☐ Asthma	☐ Eye/Ear	☐ Mental Health Issues	☐ Suicide Attempt
☐ Cancer	☐ Fainting	☐ Migraines	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart	☐ Painful Menstruation	☐ Other Serious Illness
☐ Diabetes	☐ High Blood Pressure	☐ Panic Attacks	☐ Handicapping Conditions
☐ Eating Disorder	☐ Kidneys	☐ Skin	

Explanation of all YES answers: _____

_____

_____

Are your immunizations up to date? (circle) Yes No

If you were home schooled or you are an international student, you **MUST** provide an immunization record.

PLEASE COMPLETE REVERSE SIDE ALSO

Permission for Treatment

Sign below for authorization of treatment

Student Signature _____ Date _____

If you are not 18 at the time of signing, a parent or guardian **MUST** sign as well.

Parent/Guardian Signature _____ Date _____

Personal Information

Height _____ Weight _____ Do you take any medications routinely? (circle) Yes No

If yes, what medications? _____

_____

Are you allergic to any medications? (circle) Yes No

If yes, what medications? _____

_____

Insurance Coverage

If you are enrolled full-time, you **MUST** have health insurance coverage.

Do you currently have health insurance? (circle) Yes No

If the answer is **NO**, you are **required** to sign up for the campus health insurance as we require health care coverage for our full-time students.

☐ Please bill my student account for the insurance plan offered by the college.

If you have insurance coverage, you **must** complete below:

Insurance Name _____

Policy ID Number _____

Primary Policy Holder's Name _____

Membership/Customer Service Phone Number: _____

You <u>MUST</u> attach a copy of your health insurance card to provide proof of your insurance coverage.

Release of Medical Information

I, _____ , authorize Kentucky Wesleyan College's Health Service to notify my parents, guardian, academic dean office and professors of illness that would impair my ability to attend class.