ALABAMA STATE UNIVERSITY

REPORT OF HEALTH EVALUATION

Return to:

ASU Health Center
P.O. Box 271
Montgomery, AL 36101

Student ID Number _____

Semester to Enroll **Summer Fall Spring 20** _____

THIS PAGE TO BE COMPLETED BY STUDENT

Full Name _____ Birthdate _____ Sex/Gender _____
(Last) (First) (MI) (Mo) / (Date) / (Yr)

Home Address _____ Email Address _____

City_____ State _____ Zip _____

Telephone Numbers: _____ (home) _____(cell)

In case of medical emergency, notify _____ Relationship _____
Name

Address _____ City _____ State_____ Zip _____

Telephone Number: _____(cell) _____ (work) _____(home)

MEDICAL HISTORY

1. Do you have any medical problems? (*ex.,* asthma, diabetes, high blood pressure, lupus, sickle cell disease, seizures, etc.)
   Yes___ No ___ If yes, please explain _____
   _____
2. Have you consulted a physician or been hospitalized within the past five years? Yes ___ No ___ If yes, please explain
   _____
   _____
3. Please list any surgery(s), acute or chronic illnesses, and significant injuries which you have had including dates
   _____
   _____
4. Have you ever been treated for mental or emotional disorders? Yes ____ No ___ If yes, please explain _____
   _____
   _____
5. Are you taking any medications regularly at the present time, or have you taken any in the past (including allergy injections, antidepressants, contraceptives, etc.)? Yes ___ No ___ If yes, please list _____
   _____
6. Are you allergic to any medications, foods, or other substances? Yes ___ No ___ If so, list and describe reactions
   _____
   _____

Health Center Use Only:

Hold _____

Status _____ **HLD Released** _____

Student Number: _____

The American College Health Association recommends all first year students living in residence halls get immunized against meningococcal disease and tuberculosis.

THIS PAGE TO BE COMPLETED BY PHYSICIAN/CRNP

IMMUNIZATION DATES (Please provide a copy of your childhood shot record).

If born after 1957, show proof of two measles vaccines-done since birth or proof of having the measles.

(1) Required MMR #1 date: Required MMR #2 date:

(2) Required TB Test within last 12 months

Date Administered/Site: _____ Signature/Title: _____

Date Read: _____ Numerical results only_____mm Signature/Title: _____

If TB skin test is positive, Chest x-ray: Date: _____ Results: _____
T-Spot or QuantiFERON® results _____

Please attach copy of x-ray or lab test results. _____

Signature of Provider

REQUIRED PHYSICAL EXAM BY PHYSICIAN/CRNP

Blood Pressure _____ Pulse Rate _____ Respirations _____ Height: _____ Weight: _____ lbs

Systems Review	Within Normal Limits	Abnormalities
Eyes, Ears, Nose, Throat		
Cardiovascular		
Respiratory		
Gastrointestinal		
Breast		
Genitourinary		
Musculoskeletal		
Endocrine		
Integumentary		
Neuropsychiatric		
Teeth		

Is there loss of, or seriously impaired organ? Yes _____ No _____

Recommendation for physical activity? Limited _____ No _____

Do you have any recommendations regarding the care of this student? Yes _____ No _____

If yes, explain_____

Is this patient currently under treatment for any medical or emotional conditions? Yes _____ No _____ If yes, explain

_____

Remarks _____

Provider's Signature _____ Date of Examination _____

Address _____ **Office stamp**:

_____

DEADLINE FOR SUBMISSION: June 30 for Fall Semester, October 30 for Spring Semester, April 30 for Summer