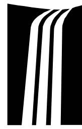

TOCCOA FALLS
COLLEGE

I.D. #____________________________
For office use only

MEDICAL HISTORY FORM

ENROLLMENT INFORMATION

Type of Student: ☐ New ☐ Transfer ☐ Former ☐ International Status: ☐ Full-time ☐ Part-time
☐ Dual Enrollment ☐ Online Only (Online Only Students do not need to complete Medical Forms.)
Semester: ☐ Fall ☐ Spring ☐ Summer Year: 20______ Housing: ☐ On-Campus ☐ Off-Campus
Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

DEMOGRAPHIC INFORMATION

Full Legal Name:____
Last (Family Name or Surname) First (Given Name) Middle or Maiden

Preferred First Name____

Permanent Address____
Number and Street

____
City/Town County State/Province Zip/Postal Code Country

Home Phone: (_____)_______-________ Social Security Number: ______-______-______ Date of Birth: ____/____/____
mm dd yy

TUBERCULOSIS SCREENING

Have you ever lived in or had prolonged visits to a country outside of the US? ☐ yes ☐ no

Have you lived in or worked in a high-risk congregate setting (eg. correctional facility, long-term care facility, homeless shelter)? ☐ yes ☐ no

Have you ever had close contact with persons known or suspected to have active TB disease (eg. medically underserved, low-income, or abusing drugs or alchol)? ☐ yes ☐ no

If you answered "yes" to any of the above questions, please complete the Tuberculosis Screening Form. (See online link to Tuberculosis Screening Form under Medical Forms.)

FAMILY HEALTH HISTORY

Have any of your relatives had any of the following diseases or disorders? If yes, please explain relationship to you.

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Cancer	☐	☐	__________	Mental Illness	☐	☐	__________
Diabetes	☐	☐	__________	Migraine Headaches	☐	☐	__________
Epilepsy	☐	☐	__________	Tuberculosis	☐	☐	__________
Heart Disease	☐	☐	__________				

PERSONAL HEALTH HISTORY

Have you ever experienced any of the following?

	YES	NO		YES	NO		YES	NO
Anemia/Blood Disease	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐
Appetite Loss	☐	☐	Fainting	☐	☐	Mumps	☐	☐
Arthritis	☐	☐	Fibromyalgia	☐	☐	Obesity	☐	☐
Asthma	☐	☐	Hay Fever	☐	☐	Paralysis	☐	☐
Back Problem	☐	☐	Head Injury	☐	☐	Physical Limitations	☐	☐
Bronchitis/Chronic Cough	☐	☐	Headaches/Recurrent	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Hearing Problems	☐	☐	Scarlet Fever	☐	☐
Chicken Pox/Varicella	☐	☐	Heart Murmur or Disease	☐	☐	Severe Cramps	☐	☐
Chronic Diarrhea	☐	☐	Hepatitis	☐	☐	Shortness of Breath	☐	☐
Chronic Ear Infections	☐	☐	Hernia	☐	☐	Sinusitis	☐	☐
Colitis, Ulcerative/Spastic	☐	☐	HIV Positive	☐	☐	Sprains, Recurrent	☐	☐
Congenital Disease	☐	☐	Hypertension	☐	☐	Stomach Trouble	☐	☐
Convulsions	☐	☐	Insomnia	☐	☐	Strep Throat, Frequent	☐	☐
Cystitis	☐	☐	Joints, Injury or Disease	☐	☐	Thyroidism, Hyper/Hypo	☐	☐
Depression	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Diabetes/Hypoglycemia	☐	☐	Malaria	☐	☐	Unconsciousness	☐	☐
Dizziness	☐	☐	Measles	☐	☐	Venereal Disease	☐	☐
Eating Disorders	☐	☐	Mental Disorder	☐	☐	Vision Problems	☐	☐
Eczema	☐	☐	Migraines	☐	☐	Other	☐	☐

If you answered yes to any of the previous questions, please explain.____

____

____

ALLERGIES AND MEDICATIONS

Do you have any drug allergies? ☐ yes ☐ no If yes, please explain.___________________________________

Do you have any non-drug allergies? ☐ yes ☐ no If yes, please explain.___________________________________

Do you carry an epipen? ☐ yes ☐ no

Do you take any prescription medications regularly or frequently? ☐ yes ☐ no If yes, please explain: ______________

____

Do you take any non-prescription medications regularly? ☐ yes ☐ no If yes, please explain: ____________________

____

____

IMMUNIZATION HISTORY

☐ I am a Georgia resident or recieved many of my immunizations while living in Georgia. My results may be available in the Georgia Registry of Immunization Transactions and Services.

Hepatitis B Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age.

Hepatitis B Immunization Dose #1 _____/_____/_____, Dose #2 _____/_____/_____, Dose #3 _____/_____/_____.
mm dd yy mm dd yy mm dd yy

OR

☐ Proof of Immunity—include documentation.

Measles, Mumps, Rubella (MMR) Two doses are required for students born after January 1, 1957.

MMR Dose #1 _____/_____/_____, Dose #2 _____/_____/_____
mm dd yy mm dd yy

OR

☐ Proof of Immunity—include documentation.

Tetanus Td booster dose or Primary series within the last ten years.

Booster: Td dose within the last ten years. _____/_____/_____
mm dd yy

OR

Booster: Tdap (preferred) to replace a single dose of Td for booster. _____/_____/_____
mm dd yy

OR

Primary Series within the last ten years. Dose #1____/____/____, Dose #2____/____/____, Dose #3____/____/____.
mm dd yy mm dd yy mm dd yy

Varicella

Born in U.S. before 1980? ☐ Yes ________ , Date______/_____/_____
mm dd yy

OR

History of Disease? ☐ Yes ________ , Date______/_____/_____
mm dd yy

OR

2 doses of vaccine Dose #1 _____/_____/_____, Dose #2 _____/_____/_____
mm dd yy mm dd yy

OR

☐ Proof of Immunity—include documentation.

Meningitis (Meningitis vaccine is highly recommended.)

Meningitis Immunization Dose #1 _____/_____/_____, Dose #2 _____/_____/_____
mm dd yy mm dd yy

OR

☐ Meningitis waiver: By signing the Meningitis Vaccine Waiver I am indicating my understanding of the risks of Meningitis and desire to waive being protected against Meningitis (see online link to Meningitis Vaccine Waiver under Medical Forms).

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:______________________________ Home Phone Number:__________________________

Emergency Contact Relationship to Student:________________ Work Phone Number:___________________________

HEALTH INSURANCE INFORMATION

Primary Insurance Company Name:_______________________ Company Address:_____________________________

Name of Policy Holder:_________________________________ Relationship to Student:_________________________

Policy Holder's Date of Birth:_________/________/___________ Effective Date:___________/_________/____________

Group and/or ID Number:_______________________________ Policy Number:________________________________

Claims Address and/or Phone Number____

____

CERTIFICATION STATEMENT

By signing my name below I certify that all the information provided is true and complete to the best of my knowledge. I also certify that I have no abnormality, limitation, or restriction not mentioned on this form. I agree to notify Student Health Services of any changes that occur in my physical or mental health prior to and during my attendance at Toccoa Falls College. I also understand that if I desire to participate in intercollegiate athletics, I must have a sports physical (Sports Physical Form available at www.tfcathletics.com/d/Sports%20Physical.pdf) on file before I will be allowed to begin conditioning, practice, or competition.

____ ________________________________

Student Signature Date

Students who will be under the age of 18 on check-in day must also have their parent or guardian complete and submit a Consent for Treatment Form before attending classes. (See online link to Parental Consent Form under Medical Forms.)

Students with questions concerning the Medical Forms should call Health Services at 706-886-7299 Ext. 5304.
The information that you send to Toccoa Falls College is held in strictest confidentiality.
It can be released only with your written permission.

Please return this form (and waivers or sports physical, if applicable) to:

Mail: Toccoa Falls College
Student Health Services
107 Kincaid Dr. | MSC 787
Toccoa Falls, GA 30598
or Fax: (706) 282-6026