Toccoa Falls College Medical History Form

Fields marked with * are required fields.

YOU MUST COMPLETE MEDICAL FORMS IF YOU ARE ENROLLED FOR 6 OR MORE CREDIT HOURS ON CAMPUS. ONLINE ONLY STUDENTS ARE NOT REQUIRED TO COMPLETE MEDICAL FORMS.

Please complete and return by

Mail:
Student Health Services
Toccoa Falls College
107 Kincaid Dr. MSC 787
Toccoa Falls, GA 30598

OR Fax:
706-282-6026

OR email health@tfc.edu

Please call (706)886-7299 ext. 5304 or email health@tfc.edu with questions.

DEMOGRAPHIC INFORMATION

Full Legal Name: Last, First and Middle *

_____ _____ _____

Preferred First Name _____

Date of Birth* :

_____ _____ _____
MM DD YYYY

Social Security _____ _____ _____
XXX XX XXXX

Address *

_____
Number and Street

_____
Address Line 2

_____ _____
City State

_____ _____
Postal/Zip code Country

Email* _____

Phone Number* _____ _____ _____

XXX XXX XXXX

Toccoa Falls College Medical History Form (2)

ENROLLMENT INFORMATION*

Gender* Male _____ Female _____

Term * Fall _____ Spring _____ Summer _____

Year* 20_____

Type of Student * New _____Transfer _____Readmit _____

Status * Traditional Full-time _____ Traditional Part-time_____ Dual Enrolled _____

Housing * On-Campus_____Off-Campus _____

EMERGENCY CONTACT INFORMATION*

Please indicate a contact person in case of an emergency

Emergency Contact Name_____

Relationship _____

Phone Number _____ _____ _____

####

MEDICAL INSURANCE INFORMATION

Please enter your Medical Insurance Information, if applicable.

Insurance Company _____

Insurance Company Street Address _____

Address Line 2_____

City _____ State/Province/Region_____

Postal/Zip Code_____ Country _____

Insurance Company Phone Number _____ _____ _____

####

Name of Insured _____ _____

First Last

Toccoa Falls College Medical History Form (3)

Insured Date of Birth _____ _____ _____

MM DD YYYY

Policy/ID Number _____

FAMILY HEALTH HISTORY*

Check all that apply to your immediate family (parents, siblings, grandparents).

_____ Asthma/Lung Problems

_____ Blood Disorder/Anemia

_____ Cancer

_____ Cardiac Disease

_____ Diabetes

_____ Hypertension

_____ Liver Disorder/Hepatitis

_____ Migraine Headaches

_____ Psychiatric Disorder

_____ Seizure Disorder

_____ Tuberculosis

If yes, please explain relationship:_____

_____

PERSONAL HEALTH HISTORY *

Check All That Apply

_____ Anemia/Blood Disease

_____ ADD/ADHD/Dyslexia

_____ Asthma/Lung Problems

_____Cancer

_____Depression/Anxiety/Bi-Polar

_____Diabetes/Hypoglycemia

_____ Eating Disorder/Low Weight/Obesity

_____Dizziness/Fainting

_____ Tuberculosis

_____ Eczema/Skin Disorder

_____ Heart Disease/Condition

_____ Headaches (recurrent)

_____ Hypertension

_____ Hepatitis/Liver Disorder

_____ Musculoskeletal Disorder

_____ Kidney/Urinary Problems

_____ Stomach Trouble/GI Issues

_____ Neurological Disorder/Seizures

_____ Vision or Hearing Problems

_____ Thyroid Disorder

_____Other

If yes, explain: _____

_____

_____

_____

ALLERGIES

Drug Allergies *_____ Yes _____ No

If yes, please explain: _____

Non Drug Allergies *_____ Yes _____ No

If yes, please explain: _____

Do you carry an Epipen? *_____ Yes _____ No

PRESCRIPTIONS AND MEDICATIONS

Do you take prescription medicine? *_____ Yes _____ No

If yes, please explain: _____

Do you take any NON–prescription medication on a regular basis? *_____ Yes _____ No

If yes, please explain: _____

Toccoa Falls College Medical History Form (5)

IMMUNIZATION HISTORY *

Required Immunizations

The following immunizations are required for admission to Toccoa Falls College if you are taking 6 or more credits per semester on-campus.

Hepatitis B x 3 doses
MMR x 2 doses
Primary Series and Td or Tdap within the last 10 years
Varicella (Chicken Pox) x 2 doses
Meningitis Vaccine or signed Waiver

I am a Georgia resident or received many of my immunizations while living in Georgia *
_____ Yes _____ No - If no, please complete the following required immunization information.

HEPATITIS B *

Three doses are required or alternatives/exceptions as noted.

Hepatitis B (#1)
_____/_____/_____
MM DD YYYY

Hepatitis B (#2)
_____/_____/_____
MM DD YYYY

Hepatitis B (#3)
_____/_____/_____
MM DD YYYY

OR Hepatitis B Immunity
_____ Laboratory Proof of Hepatitis B Immunity. Please submit documentation.

MEASLES, MUMPS, RUBELLA (MMR) *

Two doses are required or alternatives/exceptions as noted.

MMR (#1) _____/_____/_____
MM DD YYYY

MMR (#2) _____/_____/_____
MM DD YYYY

OR Measles, Mumps, Rubella Immunity

_____ Laboratory proof of MMR Immunity. Please submit documentation.

**TETANUS, DIPTHERIA, PERTUSSIS (DPT) ***Primary Series

Dose #1 _____/_____/_____
MM DD YYYY

Dose #2 _____/_____/_____
MM DD YYYY

Dose #3 _____/_____/_____
MM DD YYYY

Dose #4 _____/_____/_____
MM DD YYYY

Dose #5 _____/_____/_____
MM DD YYYY

TETANUS (Td or Tdap) booster dose within the last 10 years _____/_____/_____
MM DD YYYY

Toccoa Falls College Medical History Form (7)

VARICELLA (CHICKEN POX) *

Two doses are required or alternatives/exceptions as noted.

Varicella Immunization Dose #1 _____/_____/_____

MM DD YYYY

Varicella Immunization Dose #2 _____/_____/_____

MM DD YYYY

OR History of chicken Pox Illness. Please indicate approximate date.
_____/_____/_____
MM DD YYYY

OR Varicella Immunity
_____ Laboratory Proof of Varicella Immunity. Please submit documentation.

OR Birth before 1980.
_____ Birth before 1980

MENINGITIS *

Please complete dates of vaccine doses (1 dose must be completed after age 16) **OR** complete Meningitis Waiver. (Meningitis Vaccine is strongly recommended.)

Meningitis Dose #1
Menactra, Menomune, or Menveo
_____/_____/_____
MM DD YYYY

Meningitis Dose #2
Menactra, Menomune, or Menveo
_____/_____/_____
MM DD YYYY

OR Meningitis Vaccine Waiver
_____By signing the Meningitis Vaccine Waiver I am indicating my understanding of the risks of Meningitis and desire to waiver being protected against Meningitis. (Please attach Meningitis waiver.)

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 the 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 complete and submit the separate Athletic Health and Medical Compliance Packet before I will be allowed to begin conditioning, practice or competition.

Applicant Signature*_____

Date *

_____ _____ _____

MM DD YYYY

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