

LA SIERRA UNIVERSITY

Medical History Form

Name _____ Date of Birth ____/____/____

Dates of Travel _____ Destination _____

School / Work Address _____ Phone (____) _____

Home Address _____ Phone (____) _____

Parent or Guardian (if under age 18) _____ Phone (____) _____

Person to notify in case of emergency _____

Daytime Phone (____) _____ Evening/ Night Phone (____) _____

Alternative person to notify in case of emergency _____

Daytime Phone (____) _____ Evening/ Night Phone (____) _____

Physician's Name _____ Hospital preference _____

PLEASE COMPLETE THE FOLLOWING:

Have you had (or do you presently have) any of the following? If you answer "yes" to any of the following questions, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

	<u>Circle One</u>			<u>Circle One</u>	
Head injury	Yes	No	Impaired Vision	Yes	No
(Concussion, skull fracture)	Yes	No	Frequent eye infections	Yes	No
Fainting spells (dizziness, Unconsciousness)	Yes	No	Persistent ear infections	Yes	No
Convulsions/epilepsy/seizures	Yes	No	Loss of hearing	Yes	No
Asthma or wheezing	Yes	No	Cancer or malignancy	Yes	No
High blood pressure	Yes	No	Severe skin disease	Yes	No
Kidney/bladder infections	Yes	No	Palpitations of the heart or arrhythmias	Yes	No
Hernia	Yes	No	Heart murmur	Yes	No
Diabetes	Yes	No	Migraine or other headaches	Yes	No
Allergies	Yes	No	Anemia	Yes	No
Specify _____			Neck or back injury	Yes	No
			Other injuries _____		

Have you had a recent Tetanus Booster? _____ If so, when? _____

Are you currently taking any medications? ____ If so, what? _____ Why? _____

Has the doctor place any restrictions on your activity? _____ Explain _____

Date _____

Signature of Student

Date _____

Signature of Parent or Guardian (if under 18 years)