To the Student: This form MUST be completed. Information you provide will be used as an aid to providing necessary care while you are a student. The form will not affect admission decisions but must be filled out completely and mailed to UNG Student Health Services 110 South Chestatee St, Ste 100 Dahlonega, Georgia 30597. This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and written consent.

UNIVERSITY OF NORTH GEORGIA – MEDICAL REPORT

Date of Expected Entry _____
Resident Student _____
Military Student _____
Commuting Student _____

LIST THREE TELEPHONE NUMBERS TO CALL IN THE EVENT OF AN EMERGENCY:

1. _____
2. _____
3. _____
4. _____

NAME _____ _____/_____/_____
(LAST) (FIRST) (MIDDLE) (SOCIAL SECURITY NO.)

HOME ADDRESS _____ HOME PHONE NO.(____) _____

_____
(CITY) (STATE) (ZIP CODE)

Date of exam _____ Sex _____ Marital Status _____ Age _____ Date of Birth _____

SECTION A: DISEASE AND MEDICAL HISTORY (to be completed by applicant)

Have you had or do you have:

YES / NO		YES / NO		YES / NO	
____/____	Rheumatic Fever	____/____	Stomach, Liver or Intestinal Disease	____/____	Allergies
____/____	Measles	____/____	Nervous Disorder	____/____	Migraine Headaches
____/____	Mumps	____/____	Kidney Disease	____/____	Arthritis
____/____	Meningitis	____/____	Diabetes	____/____	Pneumonia
____/____	Polio	____/____	Skin Disease	____/____	Heart Condition
____/____	Tuberculosis	____/____	Ear, Nose or Throat Problems	____/____	Irregular Heartbeat

Have you ever been hospitalized? _____ If "yes," when, where and why? _____

Have you ever received psychiatric/psychological treatment? _____ If "yes," when, where and why? _____

Are you taking medication for this treatment? _____ If "yes," list medication _____

Do you have epilepsy? _____ If "yes," list date of your last seizure _____ List medications for this _____

Do you have asthma? _____ If "yes," list date of your last attack _____ List medications for this _____

Have you had any fractured bones? If "yes," please explain _____

Do you have any joint problems, such as: shoulders, elbows, wrists, hips, knees, feet? _____ If "yes," please explain _____

Do you have migraine headaches? _____ If "yes," list date of last headache _____ List medications for this _____

Have you had any past surgeries? _____ If "yes," please explain _____

Do you have any history of injury to neck? _____ Chest? _____ Back? _____ Head? _____ If "yes," please explain _____

Are you taking any medication? _____ If "yes," please explain _____

Are you allergic to bee stings? _____ If "yes," do you use an epi-pen? _____

Are you allergic to any medications? _____ If "yes," please list _____

Do you have any physical or mental limitations that you are aware of? _____ If "yes," please list _____

SECTION B: PHYSICAL EXAMINATION (To be completed by Physician)
Mandatory for all Military Students (Optional for Others)

Height_____ Weight_____ Blood Pressure_____ Pulse_____

List any problems or observations on any of the following areas:

HEENT	Genito-Urinary System
Heart	Hemorrhoids
Lungs	Psych history (if applicable)
Abdomen (pains, scars, masses, hernia)	Congenital Abnormalities
Musculoskeletal	Others

Remarks continued:_____

I have examined the person whose name appears on the reverse side of this form pending his/her enrollment at the University of North Georgia, and find him/her:

( ) Qualified for unrestricted exercise (may include push-ups, sit-ups and running)
( ) Qualified for restricted exercise only (explain/specify below)
( ) Qualified for absolutely no physical exercise (explain below)

List any conditions that would limit this student's participation in physical activities (i.e., recent surgery or illness, chronic health problems such as trick knees or asthma, etc.) or if restricted exercise is noted above, a letter of limitations and time limit must be attached to this form by examining M.D. _____

_____

EXAMINING PHYSICIAN (PLEASE PRINT) DATE

SIGNATURE OF EXAMINING PHYSICIAN ( ) TELEPHONE NO.

ADDRESS_____

SECTION C: WAIVER/RELEASE
STUDENT WAIVER
(For Participants in the Military)

I understand that the military program at the University of North Georgia is physically strenuous and release University of North Georgia, its employees and staff from any liability in case of illness or injury sustained in training.

STUDENT'S NAME (PLEASE PRINT) STUDENT'S SIGNATURE

ALL STUDENT INFORMATION RELEASE

I hereby authorize the release of medical information to officials of the University of North Georgia from any doctor or hospital that I may utilize in case of illness or injury. I further authorize the physicians of the Student Health Services, their agents or consultants, to perform diagnostic and treatment procedures which in their judgment may become necessary while I am in attendance at the University of North Georgia.

STUDENT'S NAME (PLEASE PRINT) STUDENT'S SIGNATURE

PARENTAL RELEASE
(Students Under 18 Years of Age)

As the parent, guardian, or next of kin of _____, I give my permission for him/her to receive necessary, routine medical attention while enrolled at UNG.

PARENT/GUARDIAN (PLEASE PRINT) RELATIONSHIP ( ) TELEPHONE NUMBER

PARENT'S/GUARDIAN'S SIGNATURE

Students covered under Parent's Health Insurance should attach a copy of their insurance card to expedite treatment in the event off-campus referral is required.

SEND OR TAKE THIS FORM TO:
UNG Student Health Services 110 South Chestatee St, Dahlonega, Georgia 30597

If you need this document in a different format please e-mail cadetrecruiting@ung.edu or call 706-867-2918.