Morehouse College: Pre-Entrance HealthRecord

Please complete in ink or type only! Faxes or copies will not be accepted.

All documents must be uploaded to the Student Portal via Point and Click.

Deadline for Submission:

Fall Semester:	**June 1**
Spring Semester:	**December 1**

Student Health Services
455 Lee Street SW
Suite 300A
Atlanta, GA 30324
Phone: (404) 756-1241
Fax: (404) 756-1237

The Pre-Entrance Health Record is required before you are allowed to move into campus housing or enroll at Morehouse College. The student, parent/guardian and doctor must complete this Pre-Entrance Health Record.

- Failure to provide important medical information could result in unnecessary lab tests or screenings.
- Please make copies of the completed Pre-Entrance Health Record for your records.
- To access the Patient Portal, log in to https://MSMPortal.pointnclick.com.

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PART I

To be completed by the student and parent for authorization to treat.

Clearance to move in to campus housing or registration for classes will not be granted until all Pre-entrance health requirements have been met.

Please upload your completed health forms to the Student Portal via Point and Click.

NAME_____
Last **First** **MI**

PERMANENT HOMEADDRESS_____

City **State** **Zip** **Country**

SSN #_____ **HOME PHONE**_____ **CELL PHONE**_____

EMAIL ADDRESS_____

DATE OF BIRTH_____ **AGE**_____ **MOREHOUSE ID#**_____

ENROLLMENT DATE (Semester/Year) **FALL/**_____ **Spring/**_____

ENROLLMENT CLASSIFICATION: **□Regular F/T** **□Regular P/T** **□International** **□Transfer** **□Guest**
□Exchange/International **□Exchange-Domestic**

AUTHORIZATIONS: (Parent or legal guardian MUST sign if under 18 years of age) I hereby accept financial responsibility for the expense of health care services and I authorize the medical providers of the AUCC Student Health and Wellness Center and their agents or consultants, including emergency medical technicians, area hospitals or other treatment facilities, to perform diagnostic and treatment procedures, on the above named student, which in their judgment may become necessary while he attends Morehouse College. I have no expectation for Morehouse College to pay medical expenses for the student should he need treatment outside of Student Health Services. I agree to absolve and hold harmless Morehouse College in making medical decisions for the student. I understand that every effort will be made to notify the parent or legal guardian once permission is obtained from the student in the event of a major illness or injury. I understand that the parent or guardian may not necessarily receive notification prior to treatment.

Student Signature _____ Date_____

Parent/Guardian Signature_____Date_____

EMERGENCY CONTACT PERSON:

NAME_____RELATIONSHIP_____

ADDRESS_____

DAY TIME PHONE NUMBER ( )_____NIGHT TIME PHONE NUMBER ( ) _____

Secondary Emergency Contact

NAME_____RELATIONSHIP_____

ADDRESS_____

DAY TIME PHONE NUMBER ( )_____NIGHT TIME PHONE NUMBER ( ) _____

[TO BE COMPLETED BY STUDENT HEALTH SERVICES PERSONNEL]

Status: Complete □Reviewed By:_____Date_____

Incomplete □Checklist Indicating Missing Information Sent 1st Date Returned_____2nd Date returned_____

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MUST BE COMPLETED BY MEDICAL PROVIDER

Name of Student: _____

This form must be completed and signed by your health care provider based on an examination. ***ALL ITEMS ARE REQUIRED!!***

DRUG ALLERGIES: ☐ Yes ☐No I f yes, to what? ☐PCN ☐Sulfa ☐Erythromycin ☐ other_____

If yes, what is the nature of the reaction?_____

FOOD ALLERGIES: ☐Yes ☐No If yes, to what?_____

If yes, what is the nature of the reaction?_____

Blood Pressure_____Pulse_____Height_____Weight_____BMI_____

Is this student receiving treatment or care for any acute or chronic medical condition? ☐Yes ☐ No If yes, please explain

_____

Does this student require special accommodations because of any chronic medical condition? ☐Yes ☐ No If yes, what is the medical condition and the special accommodations required _____

_____

Is this student receiving therapy for any emotional or psychiatric condition? ☐Yes ☐ No If yes, please explain

_____

Does this individual require special accommodations because of the emotional or psychiatric condition? ☐Yes ☐No If yes, what accommodations are required? _____

_____

Has this individual had any surgical procedures? ☐Yes ☐ No I f yes, please explain

_____

Are there any learning disabilities or learning challenges that require medication for management? ☐Yes ☐ No If yes, please explain indicating medication, dosage and frequency._____

_____

Does the student have food issues requiring special diet? ☐Yes ☐ No If yes, please explain the nature of the food issue and specific diet required _____

_____

May the student participate in an athletic, sports or college wellness program? ☐Yes ☐ No If no, please explain_____

_____

Physician Signature and Official office stamp required – May not be signed by a family member

M.D./D.O./N.P./P.A.'s Name (please print)_____

Signature_____

Address_____

Date of Exam_____Telephone number ( )_____

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Name of Student: _____

MEDICAL HISTORY AND DOCUMENTATION OF NEED FOR SPECIAL ACCOMODATION

Specific requests for accommodations must be initiated by completing the **Counseling & Disability Services Verification and Request for Accommodation** form. Please list all medications and nonprescription medications this student currently takes, as well as the dosage.

_____

_____

REQUIRED SCREENING FOR TUBERCULOSIS (Within the past 12 months)

The PPD skin test must be **placed and read** before the student will be allowed to move into campus housing. Quantiferon Gold blood test also accepted with lab documentation. NOTE: If PPD is greater than 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment or other TB prophylaxis treatment should be initiated. *NOTE: PPD test should be mantoux within the past year (*tine or momovac not acceptable).*

	Date Placed	Date Read	Results
PPD*	_____	_____	_____

mm induration (horizontal diameter) Note *: If greater than 10mm induration, chest X-ray required*

If positive, provide_____
with documentation. X-Ray results: ☐ Normal ☐Abnormal.

If chest x-ray is abnormal, has patient begun INH treatment or other TB prophylaxis treatment? ☐ Yes ☐No

If no, please explain _____

Received BCG: ☐Yes ☐ No If yes, chest X-Ray required with documentation. X-Ray results: ☐ Normal ☐Abnormal

COVID PCR or Rapid Antigen test: Date:_____

(PCR must be within 3 days prior to arrival to campus, or Rapid Antigen test must be completed 2 days prior to arrival. Results must be uploaded to Point and Click.)

REQUIRED SCREENING FOR SICKLE CELL (*ATHLETES ONLY*)

Sickle Cell Results: □ Normal □ Trait □ Disease
Sickle Cell date of test: _____

Physician Signature and Official stamp Required – May not be signed by a family member

M.D./D.O./N.P./P.A.'s Name (please print)_____

Signature_____

Address_____

Date of Exam_____Telephone number ( )_____

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CERTIFICATE OF IMMUNIZATION

Student ID:_____-_____-_____

Name: (Last)_____(First)_____(Middle)_____

Address:_____

City:_____State:_____Country:_____Zip Code:_____

Term/Year of Application: Age at time of application:_____Date of Birth (mm/dd/yyyy):_____/_____/_____

REQUIRED IMMUNIZATION INFORMATION *(See the Immunization Requirements & Recommendations for USG Students documentation)*

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR[1]	/ /	/ /			
Hepatitis A[2]	/ /	/ /	/ /	Type Series: □ 2 Dose Series □ 3 Dose Series	/ /
Meningococcal ACWY[4,5] (MCV4)	/ /	/ / MCV4 Booster[6]			
Meningococcal B[6]	/ /	/ /	/ /	Type Series: □ 2 Dose Series □ 3 Dose Series	
Varicella[2]	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough)[3]	/ / Tdap	/ / Td Booster[3]			
Hepatitis B[2]	/ /	/ /	/ /	Type Series: □ 2 Dose Series □ 3 Dose Series	/ /
Covid	/ /	/ /	Vaccine Given: □ Pfizer □ Moderna □ Johnson& Johnson	Type Series: □ 1 Dose Series □ 2 Dose Series	

1—Not required if born before 1957. **2**—Required for all US born students born in 1980 or later; all foreign born students regardless of year born. **3** – Td booster only necessary if > 10 years since Tdap dose. **4** – Required if residing in campus housing, sorority housing, or fraternity housing. **5** – MCV4 Booster necessary if initial MCV4 dose was received more than 5 years to admittance. **6** – Consider if younger than 23 years of age.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

□ This student is exempt from the above immunizations on the ground of permanent medical contraindication.

□ This student is temporarily exempt from the above immunization until _____/_____/_____(mm/dd/yyyy)

CERTIFICATION OF HEALTH CARE PROVIDER *(This information is required)*

Name:_____Signature:_____

Address:_____

Date of Issue:_____/_____/_____Telephone:_____

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PART III

Name of Student: _____

Please answer each question to the best of your ability. Your answers will help us better serve your fitness needs as a new student.

□None (No exercise activity)
□Light (Slow walking, limited activity, non-structured exercise)
□Moderate (Cardiovascular exercise (walk, run, aerobic, yoga, etc.) for thirty (30) minutes, days per week?

1-2 _____
3-4 _____
5 _____
6-7 _____

□Heavy/Intense (Walk 30-40 minutes, 3-4 or more times per week, structured exercise, weight training days per week?)

1-2 _____
3-4 _____
5 _____
6-7 _____

□ Strength, (Resistance training, days per week?)

1-2 _____
3-4 _____
5 _____
6-7 _____

If you participated in a formal wellness class, what would be accomplished by participating in a fitness program? (Please check all that apply.

□Reduce Pain
□Increase Strength
□Increase Function
□Return to Full Activity
□ Improve Posture
□ Prevent Surgery
□ Improve Flexibility
□ Lose Weight:_____lbs
□ Increase Cardiovascular Endurance
□ Gain Weight:_____lbs
□ Prepare for Surgery
□ Other: _____

On average, how many fruits and vegetables do you consume daily?

0 servings per day _____
1-2 servings per day _____
3-4 servings per day _____
5 or more servings per day _____

How much water do you drink daily?

Ounces_____
Glasses _____

On average, how much sleep do you get each night>

Less than four (4) hours _____
Six (6) to seven (7) hours _____
Four (4) to five (5) hours _____
More than seven (7) hours _____

Do you struggle to say awake in the daytime?_____Yes_____No

Student Health Insurance

Morehouse College requires all degree-seeking students to have health insurance or purchase the College sponsored plan. All students are charged for the college-sponsored plan up front, however you may elect to waive or opt out of this plan.

In order to **"opt out of enrollment"** in the college sponsored plan, students and families must provide evidence of current enrollment in a health insurance plan licensed to do business in the United States, with a claims payment office with a U.S. phone number and offers an Annual Maximum comparable to the student health insurance offered by the college.

This coverage includes medical and mental health care, within the Atlanta area, that extends beyond **emergency-only** coverage and covers pre-existing conditions as well as prescription drugs.

If you do not wish to purchase the college sponsored plan, you **must opt out or waive the plan by** the deadline of **September 6th for fall enrollment** and **December 20th for spring enrollment.**

If your request to waive or opt out is declined, you will receive notification through the email address you used to complete the waiver along with instructions to appeal by printing the **"Appeal/Insurance Verification"** form and submitting this to your insurance carrier.

Failure to opt out or waive the college sponsored student health insurance plan will result in a fee being added to the student's account. If you wish to enroll in the college-sponsored plan, do nothing; the fee will be added to your account!

MEDICAL INSURANCE INFORMATION

Completion of this portion of the form does **NOT** serve as the waiver/opt-out form

FOR USE BY STUDENT HEALTH SERVICES ONLY

Insurance Company Name: _____

Address _____

Street City State Zip

Telephone: (____) _____

Policy Holder Name: _____

ID Number: _____ Group Number: _____