College of Charleston
Student Health Services Health Form

181 Calhoun Street
Charleston, SC 29424
Phone 843-953-5520 Fax 843-953-6377

Student ID Number

Last Name (Print) | First Name | Middle | Student phone #/cell #

Home Address | City/Town | State/Country | Zip Code

Next of Kin | Relationship | Address

Next of Kin Home Phone | Next of Kin business Phone

Health Insurance/HMO/Primary Care Physician Name & Number

Citizen | Sex | Marital Status | Date of Birth | Month/Year Entering

Family History

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Family History

	Yes	No	Relationship
TB/Respiratory Disease/Asthma			
Diabetes			
Kidney Disease			
Heart Disease			
Cancer			
Depression			
Other			

Personal Medical History – Allergies

Allergies	Yes	No	Explanation/List
Drug Allergies			
Insect Bite/Sting Allergies			
Foods			
Latex			

Personal Medical History – Please comment below on positive answers

Illness/Injury	Yes	No	Year	**Illness/Injury**	Yes	No	Year	**Illness/Injury**	Yes	No	Year	**Surgery**	Year
Acne				Epilepsy				Pap Smear					
Alcohol/Drugs				Hearing loss				Abnormal Pap Smear				Fractures	
Anemia				Heart Murmur				Pneumonia					
Asthma				Hepatitis				Rheumatoid Arthritis					
Bleeding Problem				High Blood Pressure				Seasonal Allergies				Other:	
Blindness				Hypoglycemia				Sexually Transmitted Infections				**Current Medications**	
Breast Lumps				GI Problems				Sickle cell anemia/trait					
Cancer				Kidney Stones				Thyroid problems					
Chicken Pox				Mental/Emotional Problem				Tobacco use					
Cystic Fibrosis				Migraine Headaches				TB or positive PPD					
Diabetes				Mono				UTI/Bladder Infection					

This form must be completed and on file at the Student Health Service. Information you provide will not affect admission decisions. A physical is not a requirement. Please include a copy of your insurance card. Medical services can only be performed on a person under the age of 18 years with permission of the parent or guardian. In the event of serious illness or accident, every effort will be made to contact the parent or guardian, however, in the event that delay of treatment is detrimental, authorization for consultation and treatment is requested. With this understanding, permission is granted to perform emergency medical or surgical service. Expenses for services not routinely covered will be the responsibility of the parent or guardian. Students should have their own health insurance to cover such costs.

Student Signature________________________________ Date________________________

Parent/Guardian Signature________________________________ Date________________________

Immunization Record

Last Name First Name MI Date of Birth

On the recommendation of the American College Health Association and the South Carolina Department of Public Health the following immunizations are required for all undergraduate, graduate, transfer and part-time students. The 2 MMR requirement does not apply to those students born before 1957. A copy of an official immunization record may be attached in place of a health provider's signature. Please visit our website at http://www.cofc.edu/~stuhealth/immunizations.html for more detailed information regarding required and recommended immunizations. Certain recommended vaccines are for certain at-risk groups.

Required Immunizations/Tests To be completed and signed by your health care provider

A. MMR (Measles, Mumps, Rubella) Two doses at least 28 days apart for students born after 1956

1. Dose One given at age 12 months or later Date____________
2. Dose Two given 28 days after first dose or later Date____________

B. Polio Circle # of doses received 1 2 3 4 Date of last dose___________

C. Tetanus Circle one DT Td DTP T-DAP Given within the last ten years Date____________

Recommended Immunizations

A. Meningitis Vaccine Name of Vaccine__________________________ Date____________

B. Hepatitis B (Series of 3 vaccines) Dates #1 _____________ #2______________#3_______________

C. Hepatitis A (Series of 2 vaccines) Dates #1_____________ #2_______________

D. Human Papillomavirus (HPV) (Series of 3 vaccines) Dates #1 __________ #2___________ #3_____________

E. Varicella (Chicken Pox) (Series of 2 vaccines) Dates #1_____________ #2_______________

Travel Related Immunizations

A. Typhoid Oral/Injectable__________________________ Date ____________

B. Yellow Fever Date _____________

C. Polio Booster (Adult Dose) Date _____________

D. Other Vaccine(s) ________________ Date____________ _______________Date______________

Health Care Provider Signature____Date________________________________

Health Care Provider Name____Phone_______________________________

Address____