

Harcum College

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Student Name: _____
Last First MI

Date of Birth: _____ / _____ / _____ Major: _____
Month Day Year

Address: _____
Street City State Zip

I authorize the disclosure of the protected medical information listed below for the purpose of review and evaluation in connection with my course of study at Harcum College, which includes fieldwork affiliation with an outside agency.

- ✓ Physical Exam
- ✓ Immunization History
- ✓ Urine Drug Screen

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

Any facsimile, copy, or photocopy of this authorization shall serve the same effect as the original.

This authorization expires four years from the date below.

Student Name (*Please Print*): _____ Date: _____

Student Signature: _____ Date: _____

HARCUM COLLEGE

STUDENT MEDICAL HISTORY

This report is screened by the college Health Center staff and may be shared with appropriate college personnel in an emergency. Medical records are kept secure and confidential in the Health Center.

Name: _____ Social Security Number: _____
Last First MI
Birthplace: _____ Birth Date: _____/_____/_____
Month Day Year
Height: ____/____ Weight: _____ Sex: _____ Age: _____ Marital Status: _____
Feet Inches
Address: _____
Street City State Zip
Home Phone Number: _____ Cell Phone Number: _____
Major: _____ Date of Entry: _____/_____
Month Year
Status (please circle *all* that apply): **Full-Time** / **Part-Time** **Resident** / **Commuter**

EMERGENCY NOTIFICATION STATEMENT: I authorize Harcum College to notify the person named in an emergency.

Name: _____ Relationship: _____
Address: _____
Street City State Zip
Home Phone Number: _____ Cell Phone Number: _____ Work Phone Number: _____

MEDICAL INSURANCE: Please attach a copy of a medical card to this form.

SIGNIFICANT FAMILY HEALTH HISTORY:

Father: _____

Mother: _____

SIGNIFICANT STUDENT HEALTH HISTORY: _____ _____ _____

MEDICATION ALLERGIES: _____

OTHER ALLERGIES: _____

CURRENT MEDICATIONS: _____

Questionnaire: Please circle Yes or No.

- | | | |
|--|-----|----|
| 1. Do you binge/ fast or been suspected of an eating disorder? | YES | NO |
| 2. Have you ever been treated for a serious illness or admitted to a hospital?
Please List: _____. | YES | NO |
| 5. Are you currently under medical care for any physical or emotional problems?
Please List: _____. | YES | NO |
| 6. Have you ever attempted suicide? | YES | NO |
| 7. Do you feel you have a substance abuse problem? | YES | NO |

MEDICAL CARE AUTHORIZATION

I, authorize Harcum College Health Service and/ or any authorized member of its staff, or affiliated consultant, to provide care in the Health Services Center, and for emergency treatment.

Student's Signature: _____ Date: _____
Parent's Signature: _____ Date: _____

Parent's signature is required if the student will be under 18 years of age when they enter Harcum College.

PLEASE COMPLETE OTHER SIDE