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?	YES	NO
	Please List: _______________.		
5.	Are you currently under medical care for any physical or emotional problems?	YES	NO
	Please List: _______________		
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