**Student Health Center REQUIRED HEALTH FORM**

**11300 NE 2nd Avenue**

**Miami Shores, FL 33161**

**Phone (305) 899-3750**

**Fax (305) 899-3751**

You must return this completed form ***BEFORE*** you register for classes.

***THIS PAGE TO BE COMPLETED BY THE STUDENT*** (PLEASE TYPE OR PRINT)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *Last First Middle*

Local Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_

Permanent Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_

Cell: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Student ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ Current Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date Enrolled:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Your academic major at Barry University:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you participating in Barry University Intercollegiate Sports? **Yes** or **No** (*please circle one*)

If yes, what sport(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY:**  Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

***(If none, please write N/A and you may attach further documentation if necessary.)***

|  |
| --- |
| **1. List all current medications that you take for chronic or non-chronic conditions.** |
| Medicine | Dosage | Condition |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **2. List all food and/or drug ALLERGIES 3. List all medical conditions (year and diagnosis)** |
|  |  |
|  |  |
|  |  |
|  |  |
| **4. List all hospitalizations (year and diagnosis)** |
|  |
|  |

***To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my primary care provider if I, or my minor child, ever have a change in health.***

**Student Signature *(must be signed by parent or legal guardian if student is under the age of 18)* Date**