MONMOUTH UNIVERSITY

West Long Branch, New Jersey 07764-1898 • (732) 571-3464; Fax (732) 263-5353

HEALTH SERVICES
STUDENT HEALTH RECORD

THIS FORM MUST BE COMPLETED PRIOR TO ENTRY INTO RESIDENCE HALLS AND / OR PARTICIPATION IN SPORTS

PARENTAL PERMISSION (Required for students under age 18)

The law requires that parental permission be obtained for procedures on minors. The following consent form must be signed by the parent so that such procedures may be promptly carried out so that unnecessary delays will not occur with operative procedures. HOWEVER, NO OPERATION WILL BE PERFORMED, EXCEPT IN EXTREME EMERGENCY, WITHOUT PARENTS BEING CONTACTED AND FULLY INFORMED.

I give permission for such emergency diagnostic, therapeutic and operative procedures as may be deemed necessary for my son / daughter.

_____ Date _____/_____/_____

(Student's Name)

_____ Relationship _____

First Name Last Name

(Parent or Guardian's Signature)

This form is the foundation of the Student's Medical Record at Monmouth University, and is regarded as confidentiial.

Each question must be completed and the form returned to the University Health Services, BEFORE the student will be permitted to participate in sports and/or enter Residence Halls.

This is a confidential record.

NOTE: In the event of illness...

Due to the complexity of HMO's and managed care insurance, students may be required by these plans to contact their primary care physicians when services outside the Health Center are recommended.

The student, NOT the University is financially responsible for any hospital expenses and for treatment by a physician other than the University Physician, even though the student may have been transported, in an emergency, by the University personnel.

PLEASE RETURN THIS FORM TO:

HEALTH SERVICES
MONMOUTH UNIVERSITY
Cedar Avenue
West Long Branch, New Jersey 07764-1898

☐ Check if intercollegiate athlete and enter sport _____

_____ _____

Student's Name (Print) Student's Signature

MONMOUTH UNIVERSITY - Exam Required of ALL Residential Students and Athletes

This physical examination will become part of the student's record at Health Sercvices. If the student will participate in Division I Athletics, a copy of this form will be forwarded to the Coordinator of Sports Medicine. This copy MUST be on file in Sports Medicine for the student/athlete to become eligible for participation in varsity athletics (Including practice, play, etc.)

PLEASE PRINT:

NAME_____ Male_____ Female_____ Date_____
(LAST) (FIRST)

SPORT_____ Date of Birth_____ SS#_____

Home/Permanent Address_____

_____ Telephone_____

PLEASE NOTE THAT ATHLETIC PHYSICALS SHOULD BE CONDUCTED WITHIN TWO MONTHS PRIOR TO THE START OF THE SEMESTER. (July or August for September start)

To Be Completed By Primary Care Physician

Height _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____

Gross Hearing Defects: Yes _____ No_____ Comments_____

Vision: _____ Normal Vision of 20/20: Yes _____ No_____ Glasses: Yes _____ No _____ Contacts: Yes _____No_____

List Current Medications:_____ **Allergies:**_____

	NORMAL EXAM	ABNORMAL EXAM / COMMENTS
HEENT	_____	_____
HEART	_____	_____
LUNGS	_____	_____
IF ASTHMATIC - baseline peak flow rate		_____
ABDOMEN	_____	_____
Hernia	_____	_____
PELVIS	_____	_____
NEUROLOGICAL	_____	_____
MUSCULOSKELETAL	_____	_____
Range of Motion/Strength	_____	_____
Gait	_____	_____
Spine	_____	_____
SKIN	_____	_____

q **Is this individual currently being treated for any medical problem(s)? If YES, give details below.** **NO** _____
q **Is there a loss or seriously impaired function of any paired organ? (i.e. kidney, testicle, ovary) If YES, give** **NO** _____
q **Is there a history of any psychological problem in the last 5 years? If YES, give details below.** **NO** _____
q **Is there any reason this individual cannot participate in competive Division I - Intercollegiate Athletics which includes strenuous exercise/conditioning, contact and collision? If YES, give detail** **NO** _____

DETAILS: _____

_____

_____

Name of Physician: _____ Date: Signature: _____

Address:_____ Telephone:_____

PLEASE STAMP THIS FORM

Mail this form to: Monmouth University Health Services, Cedar Avenue, West Long Branch, NJ 07764-1898

MEDICAL HISTORY
(TO BE COMPLETED BY **STUDENT**)

PLEASE PRINT IN INK OR TYPE:

Name _____ SS#_____/_____/_____
(LAST) (FIRST) (M.I.)

Home Address _____ Phone (_____)_____
(STREET NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)

Local Address _____ Phone (_____)_____
(STREET NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)

Age_____ Date of Birth ____/____/____ Sex: M ☐ F ☐ Date Entering: Fall 20____, Spring 20____, Summer 20____

Parent / Guardian / Spouse / or next of kin**:**
Name_____
Address_____
(NUMBER, STREET, CITY, STATE, ZIP)
Phone(_____)_____

Family Physician:
Name_____
Address _____
(NUMBER, STREET, CITY, STATE, ZIP)
Phone(____)_____

ARE YOU COVERED BY MEDICAL INSURANCE? **(REQUIRED)** Yes ☐ No ☐ **If No -**Contact Health Services for Information.
Policy / Company Name _____ ID Number _____

FAMILY HISTORY
Has any member of immediate family had any of the following conditions: (give their relationship):

Allergy _____	Diabetes _____	High Blood Pressure _____	***Tuberculosis**_____
Asthma _____	Epilepsy _____	Kidney Disease _____	Ulcers _____
Cancer _____	Heart Condition _____	Mental Illness _____	Sickle Cell Anemia _____
Colitis _____	Hemophilia _____	Stroke _____	Other _____

PAST HISTORY - IF YOU HAVE HAD ANY ONE OF THE FOLLOWING CONDITIONS, STATE YEAR OF OCCURRENCE

Anemia _____	Eating Disorders _____	Meningitis _____
Arthritis _____	Emotional Problems _____	Migraine Headaches _____
Asthma _____	Epilepsy or Convulsions _____	Orthopedic Problem _____
Bladder Infection _____	Heart Disturbances _____	Phlebitis _____
Bleeding Tendency _____	Head Injury _____	Pneumonia _____
Bronchitis _____	Hepatitis _____	Rheumatic Fever _____
Cancer _____	Hearing/Ear _____	Surgery/Injury _____
Chicken Pox _____	High Blood Pressure _____	Thyroid Disturbances _____
Cholesterol _____	Infectious Mononucleosis _____	*Tuberculosis _____
Colitis _____	Kidney Disorder _____	Ulcers _____
Cystic Fibrosis _____	Lyme Disease _____	Visual/Eye _____
Diabetes _____	Malaria _____	Other _____

***Has the student ever lived with anyone who had tuberculosis? Yes ____ No ____ Length of Time _____

COMMENTS _____

MEDICATIONS List all medications with dosages and frequency or administration.

MEDICATION	DOSAGE	REASON FOR TAKING MEDICATION

ALLERGIES

Allergies- medications: _____
Other _____
Are allergy injections being prescribed at present? _____

Do you drink alcohol? _____ How often? _____ Do you smoke or use tobacco?_____ How Often? _____
Have you been diagnosed with a learning, psychological or physical disability? Yes _____ No _____
If Yes, please explain:_____

_____

_____

Students with learning or physical disabilities contact: Director, Department of Disability Services.
Students with psychological disabilities contact: Director of Psychological Services

TREATMENT RECORD