Truman State University

Confidential Medical History

This form must be completed before care can be provided.

Return To:

Truman Forensic Union
100 E Normal, Dept. of Communication
Kirksville, MO 63501

Name____
Last First Middle

Sex _______ Age_______ Birth date________________ Social Security #:______________________

Permanent address____ Phone__________________
Street City State Zip

Parental Contact ______________________________ Address ______________________________
(if different than above)

Phone____ Business Phone__________________________

Family Physician____ Phone____________________

Personal Health History

Do you have a present problem or past history of any of the following problems? **(check all that apply)**

___Asthma
___Bronchitis
___Cancer
___Chicken Pox
___Diabetes
___Dietary Restrictions
___Ear Trouble
___Epilepsy/Seizures
___Hay Fever
___Head Injury
___Hearing Loss
___Hepatitis/Jaundice
___Hernia/Rupture
___Intestinal Trouble
___Kidney Infections/Disease
___Mononucleosis
___Paralysis
___Sinus Trouble
___Skin Problems
___Surgery
___Tuberculosis
___Urinary Tract Infections

Allergies

___**Bee Stings** ___**Food** – please list any: __________________ __________________

___**Medications** - Please list any drug allergies you may have: __________________ __________________

Psycho/Social History

Do you have a present problem or past history of problems with any of the following? (check all that apply)

___**Eating Disorder** ___**Depression** ___**Psychological Counseling**

Medications

Other: Is there any other health information that might be helpful to us in the event of an emergency?

Health Insurance Information -Please answer the following questions as completely as possible.

Insurance coverage (Please check all that apply):

____Preferred Provider Plan ___Health Maintenance Organization ____Indemnity Plan ____ Uninsured

Policy Number ____________________________ Group Number (if applicable) ______________________________

Name of Principle Insured Person (parent or yourself) ____

I hereby certify that the above history is complete to the best of my knowledge. I authorize Kevin Minch, Kristi Scholten, Russell Luce, Kristopher Stroup, or any other Truman employee working with the forensics program to act on my behalf if I become medically incapacitated and they are unable to reach a designated family member. I further authorize them to contact my next of kin in the event of a medical emergency.

____________ ______________________________ ______________________________
Date Signature of Student Signature of Parent (if under 18)