Name: _____ Date of Birth: _____

Home Address: _____ Cell Telephone:_____

_____ Home Telephone: _____

HEALTH FORM

INSTRUCTIONS: This form must be completed, signed, and submitted for you to attend the Sewanee School of Letters. ***The information you provide will be treated as confidential.*** *It is in your best interests that this record be complete. Please attach additional sheets if necessary.*

Please return the completed form to the Sewanee School of Letters office.

I. In the space below, or on an attached sheet, indicate any chronic conditions (low or high blood pressure, diabetes, ulcer, cholesterol or blood fat disorder, alcoholism, glaucoma, depression, etc.), specifying those for which you regularly take medication:

II. Have you ever experienced adverse reactions to such drugs as penicillin, sulfa, other antibiotics (specify these), aspirin, codeine, other pain relievers (specify these), horse serum, local anesthetics, or other drugs? If so, provide details of your reaction, your age when the reactions occurred, and how often the experience has occurred.

III. Are you allergic to foods, stinging insects, molds, pollen, animals, etc.? Do you receive allergy desensitization injections? If yes to either of these questions, provide details.

IV. Do you regularly use either prescription or non-prescription medications, other than those listed in response to I, above? If yes, provide specifics.

Please provide the name, address, and telephone number of physician, psychologist, or other health caregiver you now consult:

Name _____ Field _____

Address _____

City, State, Zip _____

Telephone Number _____

List any current insurance coverage (Blue Cross/Blue Shield, private insurance company, or public assistance):

Insurance Company	Address or phone contact	Policy No.
_____	_____	_____
_____	_____	_____

It would be wise to contact the customer service department of your insurance company to see if they require notification that you will be out of your provider area for six weeks. Please make sure you are covered while **in** Sewanee.

In the event of an emergency, please notify:

Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Telephone, work: _____

Telephone, home: _____

My signature below indicates that:
—I consent to medical and nursing treatment by qualified medical personnel;
—the information on this form is correct and complete to the best of my knowledge;
—I understand that the Sewanee School of Letters views my health as my responsibility, and if I require medical services, prescriptions, or other health care services, I shall assume full financial responsibility or negotiate satisfactory arrangements with any care-giver;
—I hereby authorize the release of any information on file pertaining to my condition of health. I understand that my contacts with health and counseling services while at Sewanee are held in confidence, but I agree that confidentiality may be broken if my life or that of any other person is in danger.

SIGNATURE OF PARTICIPANT

_____

DATE

_____

Please return the completed form to the Sewanee School of Letters office.