

MEDICAL FORM

SMC requires that all students submit this completed form prior to the beginning of classes.



Will you participate in intercollegiate athletics at Spartanburg Methodist College? ___ Yes ___ No

MEDICAL HISTORY

(Please Print)

RESIDENT ___ COMMUTING ___
NAME: _____ DATE OF BIRTH: ___ / ___ / ___
 LAST FIRST MIDDLE
ADDRESS _____ CITY _____ STATE ___ ZIP _____
PARENT/GUARDIAN/SPOUSE: _____ PHONE # (___) _____
(CIRCLE ONE) (HOME)
PHONE # (___) _____
(WORK)

ADDRESS _____
(IF DIFFERENT FROM ABOVE)

NAME OF FAMILY PHYSICIAN _____ PHONE # (___) _____
ADDRESS _____ CITY _____ STATE ___ ZIP _____

CIRCLE YEAR ATTENDING: 1 2 ENROLLMENT START DATE: Mo ___ Yr ___

IF TRANSFER, COLLEGE LAST ATTENDED: _____

Students: This form and immunization record must be completed, returned, and verified by Student Health Services Personnel 15 days prior to enrollment. Satisfactory completion of this process is required before you can officially register for classes. Mail to: Admissions Office, Spartanburg Methodist College, 1000 Powell Mill Road, Spartanburg, SC 29301-5899. For further information call (864) 587-4213.

PLEASE READ CAREFULLY BEFORE COMPLETING FORM

IMPORTANT: Legal safeguards make it necessary for every student to have on file in the Health Services Office a record of medical history. The primary purposes of this medical record are to provide a basic point for reference in case of future illness, to locate possible medical conditions needing correction before it can interfere with your studies, and to provide the Health Service Staff with knowledge of any necessary continuing treatments. All information is considered confidential.

MEDICAL RECORDS RELEASE FORM

I, _____, hereby authorize Spartanburg Methodist College Health Services to release or secure copies of records pertaining to my health to or from any physician, hospital, medical care facility or medically related facility. I understand that these records are confidential and will not be shared with anyone outside of the medical profession without further authorization.

Student Signature

INSURANCE INFORMATION

Student Name _____ DOB ___ / ___ / ___ SS# ___ - ___ - ___
Parent (insured) Name _____ DOB ___ / ___ / ___ SS# ___ - ___ - ___
Insured's Employer _____ Group # (if applicable) _____
Name of Insurance Co. _____ Policy # _____
Claims Address _____

Parent Signature

** Health Insurance coverage is **strongly** recommended for all students. Health insurance coverage is **required** for all student-athletes **

I. FAMILY MEDICAL HISTORY

	IF LIVING			IF DECEASED	
	Age	Occupation	State of Health	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

List family history and relationship to you of any disease such as diabetes, hypertension, heart disease, etc. _____

II. PAST HISTORY

A. Have you EVER had:

	YES	AGE	NO		YES	AGE	NO
Asthma				Chicken Pox			
Diabetes				Measles (Rubeola)			
Epilepsy or Other Seizure Disorder				Mumps			
Pneumonia				Rubella (German Measles)			
Recurrent Bronchitis				Infectious Mononucleosis			
Surgery				Other			

Explain "Yes" answers briefly: _____

B. Do you have drug allergies? Yes ___ No ___ If yes, name of drug(s) _____

C. Do you have any other allergies? Yes ___ No ___ If yes, explain _____

III. CURRENT HISTORY

A. Do you have a disease, condition, or any physical handicap? Yes ___ No ___ If yes, explain _____

B. Are you now taking any medication regularly? Yes ___ No ___ If yes, why, name and dosage of medication _____

C. Have you ever had treatment for a psychological problem? Yes ___ No ___ Diagnosis _____

If medication is used for treatment, name and dosage _____

By whom were you treated? (Name) _____

(Address) _____

Female Only

D. Is menstrual cycle regular? Yes ___ No ___ Painful? Yes ___ No ___ If medication is used for cramps, regulation, etc., name drug and dosage _____

*** IMMUNIZATION RECORD ****
Must be completed and signed by Medical Professional

Name _____ SS# _____
 (Print) Last First Middle

Date of Birth ___/___/___

Spartanburg Methodist College REQUIRES the following immunizations upon the recommendation of the American College Health Association and South Carolina Department of Health.

ALL DATES MUST INCLUDE MONTH, DAY AND YEAR

I. M.M.R. (Mumps, Measles, Rubella) - PROOF OF 2 DOSES AFTER 1ST BIRTHDAY

___ Dose I-Immunized at 12 months of age or later, and Mo ___ Day ___ Yr ___
 ___ Dose 2 - Immunized 30 days after Dose 1 or later Mo ___ Day ___ Yr ___

Or as SINGLE DOSES as listed below -

A. Measles - PROOF of 2 doses after 1st birthday

___ Had disease confirmed by physician diagnosis in office record, OR..... Mo ___ Day ___ Yr ___
 ___ Has laboratory evidence of immune titer (Attached copy of Lab Report) Mo ___ Day ___ Yr ___
 ___ Immunized with Live Measles Vaccine at 12 mos. of age or later, AND #1 Mo ___ Day ___ Yr ___
 ___ Immunized with second dose of Live Measles Vaccine 30 days after first dose #2 Mo ___ Day ___ Yr ___

B. Mumps

___ Had disease, confirmed by physician diagnosis in office record, OR..... Mo ___ Day ___ Yr ___
 ___ Has laboratory evidence of immune titer (Attached copy of Lab Report)..... Mo ___ Day ___ Yr ___
 ___ Immunized with vaccine at 12 mos. of age or later Mo ___ Day ___ Yr ___

C. Rubella

___ Has laboratory evidence of immune titer (Attach copy of Lab Report)
 ___ Immunized with vaccine at 12 mos. of age or later Mo ___ Day ___ Yr ___

2. TETANUS-DTP-(Circle No. of Doses Received: 1 2 3 4 5) - Date of Last Dose Mo ___ Day ___ Yr ___
 Booster (Must be given within last 9 years) - DTP, DT, or Td (Circle One) Mo ___ Day ___ Yr ___

3. POLIO - (OPV, TOPV) (Circle No. of Doses Received: 1 2 3 4 5) - Date of Last Dose Mo ___ Day ___ Yr ___

4. TUBERCULIN PPD REQUIRED - (within Past Year) - Results _____ mm _____ Mo ___ Day ___ Yr ___
 (Tine Test NOT Accepted)

*NOTE: If PPD positive, a chest x-ray is required 3 months prior to class enrollment.
 Copy of x-ray results must be sent to Spartanburg Methodist College Student Health Services

5. Hepatitis B - Required - #1 _____ #2 _____ #3 _____
 (will be available through the college)

6. Meningitis _____
 (Recommended)

I certify that the above information is correct: _____
 Physician's Signature or Clinic Stamp Required

 Date