

## NEW RESIDENTIAL STUDENT MEDICAL PROFILE CHECK LIST

Please read carefully before completing form. **DO NOT RETURN THIS PAGE (page 1).**

This form (pages 2-6) must be completed, returned and verified by Coker College Health Services **BEFORE JULY 25.**

**ATHLETES: A copy of your completed Medical Profile will be given to the Athletic Trainer.**

**IMPORTANT:** Legal safeguards make it necessary for each residential student and student-athlete to have a medical, physical and immunization record on file in the Health Services Office. The physical examination is not available through the Coker College Health Services.

The primary purpose of this medical record is to provide a basic point of reference in case of future illness, to identify any medical condition requiring attention before it interferes with your studies or sport activities, and to provide the Health Services Nurse and Athletic Trainers with knowledge of any necessity for ongoing treatment. All information revealed will be considered confidential and will not interfere with acceptance in the College unless such findings would endanger other students or staff.

### PRE-MATRICULATION REQUIREMENTS CHECKLIST FOR **NEW RESIDENTIAL STUDENTS**

#### **-Mandatory-**

- Complete all pages of the health forms. **Return to Coker College Office of Student Services.**
- IMMUNITY TO MEASLES: MMR (Measles, Mumps, and Rubella) **two doses required.**  
Dose one given at 12-15 months or later. Dose two, given at least one month after first dose or later.
- IMMUNITY TO TETANUS (Tdap): Tetanus booster within **10 years prior to admission.**
- MENINGITIS VACCINE: For more information on the meningococcal vaccine go to [www.cdc.gov](http://www.cdc.gov).
- TUBERCULINE SKIN TEST (PPD): Must have within **12 months prior to admission.**  
Tine or Monovac is not acceptable. If PPD is positive, a chest x-ray is required.

#### **-Suggested-**

- HEPATITIS B VACCINE: Highly recommended to have completed the series of 3 injections.
- VARIVAX (varicella vaccine): Highly recommended if you have not had chickenpox.
- MAKE A PHOTOCOPY OF ALL HEALTH FORMS** before you mail the original form and bring the copy to school with you in the event the original form gets lost in the mail and needs to be resubmitted.

*Incomplete or missing paperwork can cause delays in registration, inability to reserve space in the residence halls, and/or for student-athletes, delays in athletic participation.*

**MAIL ENCLOSED FORM TO:**  
Coker College  
Office of Student Services  
300 East College Avenue, Hartsville, SC 29550

**HAVE QUESTIONS?? Call (843) 383-8035**



## MEDICAL EXAMINATION *To Be Completed By a Physician*

**Physical must be dated AFTER January 1st of your entering year at Coker College. No other physical accepted.**

Student's Name (Please print) \_\_\_\_\_

Hemoglobin \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_

Significant Medical History \_\_\_\_\_

Indicate "Normal", or Explain Abnormal Findings, For Each Area Listed Below

	NORMAL	ABNORMAL - Explain		NORMAL	ABNORMAL - Explain
Abdomen			Neurological		
Allergies			OB/GYN/Genitalia		
Chest / Lungs			Orthopedic		
Ears/ Nose/ Throat			Other		
Eyes			*Sickle Cell		
Heart			*Urinalysis		
Musculoskeletal					

- Y N** Do you consider this student emotionally qualified for college work/athletics?
- Y N** Do you consider this student physically qualified for college work/athletics?
- Y N** Is this student medically fit for intercollegiate sports competition? If YES, relate any precautions.  
If NO, state why. \_\_\_\_\_
- Y N** Should there be any restriction in this student's activities? If YES, please explain \_\_\_\_\_
- Y N** Have you treated this student for any significant disease or medical problem other than minor short term illness (ie. Sickle cell, diabetes, etc.)? If yes, please list problem/date/ treatment \_\_\_\_\_
- Y N** Is this student currently under your care and on medication? If yes, explain \_\_\_\_\_
1. List the name and dosage of all medications taken on a regular basis. A. \_\_\_\_\_  
B. \_\_\_\_\_ C. \_\_\_\_\_
2. Is the student allergic to any of the following? If YES, indicate type of reaction - rash, hives, breathing difficulty, etc.
- |                       |                  |                             |                     |
|-----------------------|------------------|-----------------------------|---------------------|
| a. Anesthetics _____  | d. Codine _____  | g. Inset Bites/Stings _____ | j. Penicillin _____ |
| b. Aspirin _____      | e. Demerol _____ | h. Latex _____              | k. Sulfa _____      |
| c. Barbiturates _____ | f. Food _____    | i. Morphine _____           | l. Other _____      |

**Physician's Signature** \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (printed) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**\*ATHLETES ONLY:** Coker College and the NCAA do not require these tests to be done; however, it is strongly recommended they be completed (at least prior to the first year in college).

**IMMUNIZATION RECORD**(not required for returning students)

*To Be Completed and Signed By a Physician or a Copy of Your Immunization Record.*

Name \_\_\_\_\_  
 (Last) (First) (Middle)

Coker College **REQUIRES** the following immunizations/screenings upon the recommendation of the American College Health Association, South Carolina Department of Health and U.S. Centers for Disease Control.

**ALL DATES MUST INCLUDE MONTH, DAY AND YEAR**

- A. **M.M.R.** (Measles, Mumps, Rubella) – *Two doses required*
  - 1. Dose one given at age 12-15 months or later, and ..... #1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D Y
  - 2. Dose two, given at least one month after first dose or later ..... #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D Y
- B. **Tdap** (Tetanus-Diphtheria-Pertussis) within the last 10 years ..... **BOOSTER** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D Y
- C. **Menactra vaccine** (MCV4) ..... \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M D Y
- D. **Tuberculosis Screening** (PPD required regardless of prior BCG inoculation.) PPD (Mantoux) within the past **12 months** (tine or monovac not acceptable). (If you have traveled out of the United States, a PPD is required 3 months after your return to the states.)

Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: (mm) \_\_\_\_/\_\_\_\_  
 M D Y M D Y (Signature or Stamp of MD, Nurse, Health Office)

If PPD is positive, chest X-ray is required: X-ray results: Normal \_\_\_\_ Abnormal \_\_\_\_ Mo\_\_\_\_/Yr.\_\_\_\_

**THE FOLLOWING ARE NOT REQUIRED BUT STRONGLY RECOMMENDED**

**Hepatitis B** vaccine is highly recommended. If you have had this series, please fill in dates:  
 #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Varicella** is also high recommended if you have not had chickenpox.  
 \_\_\_\_ had disease OR:  
 Vaccine given under age 13: #1 \_\_\_\_/\_\_\_\_ (month/year)  
 Vaccine given at 13 year of age and/or over (dose 1 month apart) #1 \_\_\_\_/\_\_\_\_ AND #2 \_\_\_\_/\_\_\_\_

**HEALTH CARE PROVIDER:** I certify that the above information is correct.

Date \_\_\_\_\_ Signature \_\_\_\_\_ MD, NP, RN, or \_\_\_\_\_

**MEDICAL HISTORY INFORMATION (Completed by student)**

Name \_\_\_\_\_  
 (Last) (First) (Middle)

**Family History - Who in your family currently has or had the following?**

	<b>Myself</b>	<b>Father</b>	<b>Mother</b>	<b>Brother / Sister</b>
Arthritis				
Asthma				
Blood Disease				
Cancer (Type?)				
Diabetes				
Frequent Nosebleeds				
Headaches/Migraine				
Heart Disease/Attack				
Hepatitis				
High Blood Pressure				
Kidney Disease				
Liver Disease				
Lung Disease				
Mental Illness				
Seizures				
Sickle Cell (trait)				
Stroke				

**Personal History -** Give the date and a brief description for each of the following. Use additional paper as needed.

- List Any Serious Illnesses or Medical Conditions - e.g. diabetes, epilepsy, mononucleosis. Indicate whether hospitalization was required.  
 a. \_\_\_\_\_ b. \_\_\_\_\_
- List All Surgeries - indicate date and length of hospital stay. a) \_\_\_\_\_  
 b) \_\_\_\_\_
- Are you currently being treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?  
 No \_\_\_\_ Yes \_\_\_\_ If so, please explain \_\_\_\_\_.  
 If Yes and an athlete, additional information will be needed. Please contact the Athletic Trainer for this information.
- Are you currently receiving, or have you ever received counseling or treatment for a nervous condition, psychological or emotional problem? No \_\_\_\_ Yes \_\_\_\_ If so, explain \_\_\_\_\_  
 By whom were you treated \_\_\_\_\_ Address \_\_\_\_\_  
 If medication used for treatment, name \_\_\_\_\_

**AIDS:** In accordance with the recommendations and guidelines of the U.S. Public Health Service, all students with AIDS or with a positive HIV (AIDS) antibody test are directed to report this fact to the Health Services Office as soon as they arrive on campus. Confidentiality will be maintained



### HEALTH INSURANCE INFORMATION: NEW RESIDENTIAL STUDENTS

All residential students are required to have health insurance coverage either under parent/dependent or Market Insurance student plan available through Coker College (information on this plan and how to submit an online waiver will be included in your statement from the Business Office). **This form is to be completed where applicable and signed even if you do not have personal insurance coverage.** It is your responsibility to notify the Coker College Business Office (1-800-571-7318) of any changes that occur to your policy. This includes loss of coverage. This Health Insurance form is used for information only and must be completed and on file prior to living in the residence halls.

Student Name (Print): \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_\_ If playing an Intercollegiate Sport (list): \_\_\_\_\_

No private or family coverage

▶Provide all insurance information for which you are covered. ▶Attach a photocopy of the front/back of your insurance card(s).

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder's Name: _____	Policy Holder's Name: _____
Address: _____	Address: _____
Home phone: (____) _____	Home phone: (____) _____
Relationship: _____	Relationship: _____
SS#: _____ DOB: _____	SS#: _____ DOB: _____
Employer: _____	Employer: _____
Address: _____	Address: _____
Work phone: (____) _____	Work phone: (____) _____
Insurance Co.: _____	Insurance Co.: _____
Insurance Address: _____	Insurance Address: _____
Ins. Phone #: (____) _____	Ins. Phone #: (____) _____
Policy/ID#: _____ Group #: _____	Policy/ID#: _____ Group #: _____
Type of Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO	Type of Insurance: <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Is preauthorization needed for medical/diagnostic services? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is preauthorization needed for medical/diagnostic services? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does your plan cover prescription medications? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does your plan cover prescription medications? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does your plan require a second opinion BEFORE surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does your plan require a second opinion BEFORE surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO
Primary Care MD: _____	Primary Care MD: _____
Phone #: (____) _____	Phone #: (____) _____

I authorize any insurance company, hospital, physician or other person who has attended/examined the claimant to disclose per request the release of all information with respect to any injury/illness, policy coverage, medical history, consultation, prescription, treatment, and/or all copies of medical records.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_