

UNIVERSITY SINGERS MEDICAL REPORT

2007-2008 Travel Emergency Information

Name: _____ Social Security Number: _____

Telephone: _____ E-mail: _____

Sex: ___ M ___ F Phone/Cell phone: _____ Contact: _____

Are you required to wear a health emergency bracelet? ___ Yes ___ No If yes, for what condition? _____

Have you had or do you currently have any of the following conditions? Please mark all that apply, specifying the date, whether past or current. If yes, please detail information. Attach addition sheet if necessary.

Medical Condition	Past Date	Current	If yes, please detail information
Alcohol/drug addiction	_____	_____	_____
Allergies (food, drugs, bees, etc.)	_____	_____	_____
Asthma	_____	_____	_____
Cancer	_____	_____	_____
Chronic Condition (high blood pressure, hemophilia, etc.)	_____	_____	_____
Diabetes	_____	_____	_____
Eating Disorder	_____	_____	_____
Epilepsy/Seizure Disorder	_____	_____	_____
Frequent Trouble Sleeping	_____	_____	_____
Heart Disease	_____	_____	_____
Painful shoulder, knee, back	_____	_____	_____
Thyroid Condition	_____	_____	_____
Other: _____	_____	_____	_____

Have you had any injuries which required hospital/ER attention? (i.e. major accident) ___ Yes ___ No

If yes, **when** and for **what**? _____

Have you ever been hospitalized? ___ Yes ___ No If yes, **when** and **where**? _____

Have you ever had any surgical procedures? ___ Yes ___ No If yes, **when** and for **what**? _____

What is your condition as a result of the surgery? _____

Are you currently taking medication? ___ Yes ___ No If yes, **which medications** and for **what**? Please list the dosage currently being taken. _____

Have you ever been treated for any psychological/emotional problems? ___ Yes ___ No If yes, **list dates**. _____

If yes, please describe the nature of the problem: _____

Did your treatment require medication? ___ Yes ___ No If yes, please **list medications and dosage**.

Current Status: _____

SPECIAL NEEDS: The following questions address disability-related needs for students. Provisions for the following information is voluntary.

Do you have a documented disability as defined by the American With Disabilities Act? ___ Yes ___ No

If yes, please state the nature of the disability. _____

In what areas does your disability currently impair your ability to perform daily academic activities? _____

Are you requesting accommodations for the above listed disability? ___ Yes ___ No

IF YES, PLEASE PROVIDE SEPARATE DOCUMENTATION FROM A QUALIFIED PROFESSIONAL THAT SPEAKS TO YOUR CURRENT NEEDS FOR ACCOMMODATION.

In signing this document, I verify that all of the medical and psychological information I have provided is accurate and complete, and I will notify Dr. Ratledge immediately of any relevant changes in my health that occur prior any travel. SIGNATURE: _____ DATE: _____

Please photocopy the front and back of your insurance card on one sheet of paper, aligning both images at the top of the page for maximum office efficiency.

UNIVERSITY OF ALABAMA