LYNN UNIVERSITY

HEALTH HISTORY AND AUTHORIZATION FOR MEDICAL TREATMENT FORM

Complete and forward to:
Lynn University Student Health
3601 North Military Trail, Boca Raton FL, 33431
Tel: 561-237-7231 Fax: 561-237-7705
Email: StudentHealth@lynn.edu

STUDENT INFORMATION (please print clearly) Entering Lynn **Select One** ____ **FALL** ____ **SPRING** ____ **SUMMER**

Name: _____ **Lynn Student ID:** _____ **Date of Birth:** (MM/DD/YYYY)_____

Cell phone: _____ **Email address:** _____

Gender: __ M __ F __ Other **Race:** __ African-American/Black __ Asian/Pacific Islander __ Caucasian __ Hispanic __ Multiracial/Other: ____

Permanent Address:

_____

Will the student be living on the university's campus? (select one): _____ YES or _____ NO

HEALTH HISTORY (please list details below or write "n/a" if not applicable)

1. **Allergies** (Include drug, food and environmental): ____ no known allergy or _____
2. **Current Medications** (include contraceptives, supplements, and over the counter medications - include dose and frequency):
   Please submit a separate sheet if needed.

Do you currently have or have you ever been treated for any of the following?	No	Yes	If yes, list month/year	Do you currently have or have you ever been treated for any of the following?	No	Yes	If yes, list month/year
Blood diseases, including anemia, clots, strokes or varicose veins	__	___	_____	Intestinal problems: GERD, gallbladder, ulcers, Crohn's disease, IBS, liver disease	___	___	_____
Cancer, cysts or tumors	___	___	_____	Heart problems, high cholesterol, or high blood pressure	___	___	_____
Respiratory or pulmonary problems, including asthma or bronchitis	___	___	_____	Skin problems, including infections, eczema, or psoriasis	___	___	_____
Bladder/kidney - urinary problems	__	___	_____	Immune disease - lupus- rheumatoid arthritis	___	___	_____
Diabetes, hypoglycemia or thyroid disease	__	___	_____	Infections, including, Tuberculosis, Malaria, Hepatitis, HIV, Rheumatic fever	___	___	_____
Ear, nose or throat problems, including sinusitis, ear infections, or strep throat	___	___	_____	Muscular or skeletal problems, including arthritis, fractures, or neck and back problems	___	___	_____
Genital problems, including gynecological, testicular or sexual transmitted infections	__	___	_____	Neurologic problems, epilepsy, seizures, head injury, headaches, migraines, passing out	___	___	_____
Psychological problems, including depression, anxiety, Eating disorders,	__	___	_____	Other Medical History: _____			

IN CASE OF EMERGENCY, PLEASE NOTIFY THE FOLLOWING PERSON(S): If possible, please provide a contact who resides in the United States.

Contact Name: _____ Relationship to student: _____

Contact Address:

_____

Contact Phone: _____ Email: _____ Country:

_____

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize Student Health Center to use the above stated information for any treatment or care. All protected health information will remain private confidential to Student Health staff.

Signature of Student (void unless signed):_____ Date: MM/DD/YYYY)_____

Medical consent for minors: I hereby authorize Lynn University Student Health to employ diagnostic procedures and render any treatment or care deemed necessary to the health and my well-being. I grant permission for the transfer to an accredited hospital or other care facility, in the event of serious disease, injury, or need for major surgery. I hereby consent to emergency treatment necessary to help preserve life or health. If the student is under age 18, it is understood that all reasonable efforts will be made to contact the parent or guardian, should an emergency occur, if deemed necessary by the medical provider(s) on staff. My signature below also signifies my consent to engage in the use of telehealth in my medical care with a Student Health provider or registered nurse through Lynn University Student Health. I have the right to withhold or withdraw consent at any time..

Signature of parent/guardian (if student is under 18): _____ Date: (MM/DD/YYYY)_____

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