

**Student Medical History**  
**For Special Housing Consideration**  
**Centre College**  
**600 W. Walnut St., Danville, KY 40422-1394**  
**859-238-5530 (phone) 859-238-5380 (fax)**

**CONFIDENTIAL**

**Must be completed and returned to the Parsons Student Health Center by March 1st**

ID # \_\_\_\_\_

Date \_\_\_\_\_

Class \_\_\_\_\_

Name \_\_\_\_\_

Last Name

First Name

Middle Name

Nickname or preferred name

Address \_\_\_\_\_

Street Address

City

State

Zip Code

Date of Birth \_\_\_\_\_

Month

Day

Year

**Have you ever or do you now have any of the following?**

	Yes	No		Yes	No		Yes	No
ADD .....	<input type="checkbox"/>	<input type="checkbox"/>	Eye diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Psychological counseling .....	<input type="checkbox"/>	<input type="checkbox"/>
ADHD .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia .....	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism or chemical dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disability .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Bone or joint disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disability .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble, intestinal disease, ulcer .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Major trauma, multiple injuries .....	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt .....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	Other serious illness .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis .....	<input type="checkbox"/>	<input type="checkbox"/>	Other medical problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Drug or alcohol overdose .....	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis .....	<input type="checkbox"/>	<input type="checkbox"/>	Handicapping conditions .....	<input type="checkbox"/>	<input type="checkbox"/>
Ear/nose/throat disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	Hearing/ vision impairment .....	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	Psychological problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>

**Please elaborate on what type of housing accommodations you need (single room, first floor room, off campus housing, room with private bathroom) and why you need special housing consideration that necessitates that you cannot live in a typical double room on campus with a roommate.**

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Do you have any physical handicaps or disabilities? Please explain. Yes    No

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Do you take any medication routinely? Reason and type. Yes    No

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**PLEASE NOTE: To receive special housing consideration you MUST turn this form in by March 1<sup>st</sup>. At this time requests will be categorized by Parsons Student Health Center as A) essential B) needing (assign if space becomes available) C) assign as a last priority. You will be informed of the outcome of your request by the Director of Housing by March 31<sup>st</sup>.**

**TO THE PHYSICIAN:** Please review the student's history when completing this form. This information is strictly for use by the Student Life Office and will not be released without student consent. This student has requested either off-campus or special housing. Please comment on the student's need for off-campus or special housing arrangements, which could mean a single room, a first floor room, or a private bath. The information obtained from this request form will be used to determine their eligibility.

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Additional general comments:

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I verify that the above information listed regarding medical conditions qualify this student for off-campus or special housing consideration.

Physician Name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

In order to determine a student's eligibility to receive special/single housing or off-campus housing, access to medical records, whether physical or emotional, must be obtained. Each student eighteen (18) years of age or over or the custodial parent/guardian of each student under eighteen (18) years of age agrees as follows:

I give my permission to my physician to inform the Student Life Office of Centre College, Danville, Kentucky, any pertinent health problems as requested so housing can be determined for me while I am a student at Centre College.

A photocopy of this authorization shall be valid as the original and any photocopy and the original shall expire at the date the student graduates, or otherwise permanently ceases to be a student at Centre College.

**Signatures**

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

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**STUDENT - Please be sure to read and sign the above authorization**

