

Dowell Health Center
 Towson University
 8000 York Road
 Towson, MD 21252-0001
 t. 410-704-2466; f. 410-704-3715



PRE-ENTRANCE HEALTH FORM AND IMMUNIZATION RECORD-INTERNATIONAL UNDERGRADUATE

PART I: To be completed by student. All information is strictly confidential. No information will be released without your consent. Please consult your parents or health care provider if necessary to answer the questions below.

_____ Sex: M F Birth Date: ____/____/____
 Last Name First Name MI Mo. Day Year

Social Security Number ____/____/____ Email Address _____

Permanent Address _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Phone #1: _____
 Phone #2: _____ Phone #3: _____

HEALTH INSURANCE INFORMATION: You will be automatically enrolled in the Towson University-sponsored health insurance plan and the cost will be added to your tuition bill unless you apply for and are granted a waiver. See website for minimum insurance standards and waiver application. Do NOT purchase an alternate health plan before receiving a waiver approval. I have read the above and understand the requirements.

Your signature _____ Date _____

ALLERGIES: Please list any allergies to drugs below. Also, list any allergies to food, insect stings, etc.

Name of drug other allergy	Type of reaction	Name of drug or other allergy	Type of reaction

List all medications you take regularly, including contraceptives and non-prescription drugs:

Name of drug	Strength/ dosage	Name of drug	Strength/dosage

Please tell us about any chronic health conditions , disabilities, chronic/serious illnesses which may impact your health status while at Towson University: _____

PART II. PARENTAL CONSENT TO TREATMENT OF A MINOR (If student will be under 18 at arrival on campus.)

I hereby authorize the professional staff of the Dowell Health Center of Towson University to carry out or to request such diagnostic and therapeutic measures for my son/daughter _____ as may be considered necessary or advisable by the treating provider. I also authorize the release to other physicians who may be treating my son/daughter, relevant medical information as to treatment provided my son/daughter through the university's Student Health Service. I understand I will be notified as soon as possible in the event of life-threatening illness or injury.

Signature of Parent or Legal Guardian _____ Date: _____

