TO THE STUDENT: This Student Medical Report and General Consent for Medical Treatment is part of your application for admissions to The University of West Alabama and should be completed and returned to the Admissions Office. Your admission to the University cannot be cleared until this form is received. The information contained on this form is kept on file in the University Infirmary for your protection. You are expected to report fully on the state of your physical condition. This information is used solely for the University Physician and does not affect your eligibility to enter The University of West Alabama.

Do you, or have you ever had:  

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If yes, please give details</th>
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</thead>
<tbody>
<tr>
<td>High blood pressure</td>
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<tr>
<td>Stomach ulcers</td>
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<td>Diabetes</td>
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<td>Hernia</td>
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<td>Nervous or emotional illness</td>
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<td>Epilepsy or fainting spells</td>
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<td>Psychiatric treatment</td>
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<td>Asthma</td>
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<td>Tuberculosis or lung disease</td>
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<td>Heart disease</td>
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</tbody>
</table>

Give date of your last tetanus immunization: ________________________________

Have you had any serious accident or injury or surgery? ( ) Yes ( ) No If so, explain: ________________________________

Are you presently under the care of a physician? ( ) Yes ( ) No If so, explain: ________________________________

Do you take medication on a regular basis? ( ) Yes ( ) No If so, explain: ________________________________

Are you allergic to any types of medication? ( ) Yes ( ) No If so, explain: ________________________________

Please list any other pertinent information regarding the status of your health including any medications you are currently taking: ________________________________________________________________________________________________
Date _______________________________ Signed ______________________________________

Signature of Applicant

I hereby affirm that all information supplied on this medical report is complete and accurate to the best of my knowledge. I understand that withholding information requested or giving false information may make me ineligible for admission and is reason for dismissal. I hereby give permission to the University Physician to render the evaluation and administer to me any medical aid as deemed necessary. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary. I also understand that, by signing this form, I am giving The University of West Alabama officials permission to obtain, prior to my enrollment and at anytime during my enrollment, from any physician from whom I received treatment, any medical, prescription or psychological information that they feel necessary to determine my ability to function as a responsible The University of West Alabama student. I understand that my health information may be further released to other health care providers, hospitals and/or medical clinics and laboratories. Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for a description of uses and disclosures. I hereby acknowledge I have been offered and/or received a copy of the HIPAA Privacy Practices Notice.

** A person 18 years old or younger is considered a minor. If you are under 18 years old or younger, this form must be signed by your parent or legal guardian.

I hereby certify that I have read and understand this form and I accept all its terms.

Date _______________________________ Signed ______________________________________

Signature of Applicant

I hereby certify that I have read and understand this form and I accept all its terms.

Date _______________________________ Signed ______________________________________

Signature of Parent of Guardian

*Optional (In accordance with the Privacy Act of 1974, you are not required to give your Social Security number.)

TO BE COMPLETED BY STUDENT

In the case of an emergency and/or upon recommendation of the University Physician that hospitalization is necessary to the welfare of my son/daughter, the University has my permission to admit him/her to the nearest hospital. University officials also have my permission to contact my son’s/daughter’s physician about his/her medical or psychological history and to administer any medical aid as deemed necessary.

Date _______________________________ Signed ______________________________________

Signature of Parent of Guardian

Address of Parent or Guardian

Street

City

State

Zip Code

Telephone Number

8174051v2

TO BE COMPLETED BY PARENT OR GUARDIAN OF A MINOR**

In the case of an emergency and/or upon recommendation of the University Physician that hospitalization is necessary to the welfare of my son/daughter, the University has my permission to admit him/her to the nearest hospital. University officials also have my permission to contact my son’s/daughter’s physician about his/her medical or psychological history and to administer any medical aid as deemed necessary.

Date _______________________________ Signed ______________________________________

Signature of Parent of Guardian

Address of Parent or Guardian

Street

City

State

Zip Code

Telephone Number

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