University of Delaware – Student Health Service
282 The Green, Laurel Hall, Newark, Delaware 19716-8101
Phone: (302) 831-2226 Fax: (302) 831-6407

Dear Visiting Student,

The staff of the Student Health Service is pleased that you have chosen to attend the University of Delaware. Your program requires all students to complete the Student Health Service Personal and Family Medical History and Personal Data Information forms as well as below. These three forms assist the Student Health Service medical staff to provide quality medical care. The mission of the University of Delaware Student Health Service is to provide students with quality primary health care and education about healthy lifestyles.

ALL MEDICAL RECORDS ARE CONFIDENTIAL

If you are presently under the care of a physician for chronic disease or other medical condition(s), ask your physician to forward information pertaining both to your medical problem and its treatment to Student Health Service. This will assist in continuity of your care.

Sincerely,
Timothy Dowling, D.O
Physician/Director

*If you will be **under age 18 at the time of your enrollment** it is very important that the Student Health Service have permission from either your parent(s) or guardian(s) to provide medical care until your 18th birthday. Please have one or both of them sign the consent form below:

I hereby grant permission to the Student Health Service of the University of Delaware to render medical care to my dependent _____.

Name/Relationship _____/_____

Signed _____ Date _____

Name/Relationship _____/_____

Signed _____ Date _____

EMERGENCY CONTACT INFORMATION

Student Name: _____
Family Name First Name Middle Name

Date of Birth: _____ Place of Birth _____

Name of Parent, Guardian or Spouse: _____/_____
Relationship

Address of Parent, Guardian or Spouse _____

_____

Home Telephone Number of Parent, Guardian or Spouse: _____
Please include the country code

Names, Addresses and Phone Numbers of **Two** people to be contacted in case of an **Emergency** and in the event that Parent, Guardian or Spouse cannot be notified:

1. Name: _____ Telephone: _____
   Address: _____
2. Name: _____ Telephone: _____
   Address: _____

PERSONAL AND FAMILY MEDICAL HISTORY
Student Health Service, University of Delaware

Name Family/Last,	First,	Middle	**Date of Birth** MM/DD/YYYY	**Student ID#:** (office use only)

Drug Allergies/Medicine Sensitivity

- □ None
- □ Penicillin, Ampicillin
- □ Latex Allergy
- □ Sulfa Drugs (please specify) _____
- □ Others (please specify) _____
- □ Food Allergies _____

Do you smoke?

□ Yes □ No

Current Medications – taken on a regular basis (i.e. insulin, birth control pills, seizure, or heart medicine)

□ **None**

Date Started	**Name of Medication**	**Dosage**

Current (or past) Medical Problems (i.e. seizures, diabetes, thyroid problems, asthma, heart problems, allergies, etc.)

□ **None**

Date Started	**Name of Medical Problem**

Hospitalizations and Surgeries (Please list ALL)

□ **None**

Date	

Family History of Illnesses – Please list if there is a family (e.g. grandparents, siblings) history of illness such as diabetes, high blood pressure, sudden/unexplained deaths, etc.:

_____

_____

_____

_____