

GLOUCESTER COUNTY COLLEGE

MEDICAL QUESTIONNAIRE

A completed medical questionnaire is **MANDATORY** for **ALL** students and must be submitted immediately after you have been accepted to attend this college. Please **print** all information on both sides of this form.

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____ Telephone() _____

Date of Birth _____ Sex: M ___ F ___ Banner ID No. A _____

New Student: Yes ___ No ___ Full Time _____ Part Time _____

N.J. H.S. Grad: Yes ___ No ___ School _____ Date of Graduation _____

EMERGENCY NOTIFICATION(Name of Contact)Relationship: _____

Name _____ Phone No.() _____

Address: _____

MEDICAL HISTORY: (check where applicable)

- | | | |
|---------------|----------------------------|-----------------------|
| Asthma | Hypoglycemia/Hyperglycemia | Chickenpox |
| Emphysema | Hepatitis | Cerebral Palsy |
| Heart Disease | Headaches | Chest Pain |
| Ulcers | Cancer | Partial Paralysis |
| Sinusitis | Polio | Full Paralysis |
| Alcoholism | Tuberculosis | Eyeglasses for Vision |
| Depression | Blood Disorder | Hay Fever |
| Seizures | High BP | |
| Drug Abuse | | |

SPECIAL NEEDS: (check where applicable)

- | | | |
|-------------------------------|---------------------|-----------------|
| Orthopedically Impaired | Visually Impaired | Deaf |
| Mobility Impaired | Speech Impediment | Hard of Hearing |
| Blind | Learning Disability | |
| Other (Please Specify): _____ | | |

Please list any special accommodations or equipment needed: _____

Continued on other side

ALLERGIES (Please List) _____

MEDICATIONS (Presently) Please List _____

IMMUNIZATIONS

Measles, Mumps, Rubella #2 DATE: _____

This immunization is required by the state of NJ for all full time (12 credits) students. Proper documentation of this immunization and all childhood immunization records should accompany this Questionnaire.

PERMISSION TO TREAT:

Gloucester County College requests the signature of the students (if of legal age, 18 yrs.) or parent or guardian for the authorization of emergency care should it be needed.

I authorize Gloucester County College to secure emergency medical treatment and/or call 911 in the event the above named student requires emergency care.

Signature of student or guardian

PERMISSION TO RELEASE HEALTH RECORDS

YES _____ NO _____

Signature of student or guardian

Return this form to:

Gloucester County College
1400 Tanyard Rd.
Sewell, NJ 08080