FSU
UNIVERSITY
HEALTH SERVICES
DIVISION OF STUDENT AFFAIRS

REQUIRED

STUDENT ADMISSIONS HEALTH HISTORY (Form 1)

YOU WILL NOT BE CLEARED TO REGISTER AT FSU WITHOUT THIS COMPLETED FORM (ALL PAGES)
AND ADEQUATE PROOF OF IMMUNIZATIONS ON FILE

Mail, fax, or submit forms electronically:
University Health Services
Health Compliance Office
960 Learning Way
Tallahassee, FL 32306-4178
Fax: (850) 644-8958
Electronically submit using NiFty: nifty.fsu.edu (Recipient: uhs-healthcompliance@fsu.edu)

To Verify Clearance Check
https://admissions.fsu.edu/StatusCheck/
THIS FORM REQUIRES FIVE DAYS FOR PROCESSING

Information:
uhs.fsu.edu
Insurance: (850) 644-4250
Immunizations: (850) 644-3608

SECTION A

PLEASE PRINT LEGIBLY AS ILLEGIBLE FORMS WILL NOT BE PROCESSED

NAME Last	First	Mi	DOB ___/___/___	FSU SN or FSU ID	Sex F ...M	Race
Address	**City**			**State**		**Zip**
Home Phone:( )			**Cell Phone:( )**			
Email Address:						
Primary Care Physician:	**Address**			**Phone/Fax**		

SECTION B

Please list any relevant personal medical history: _____

Please list any relevant family medical history: _____

Do you have any allergies (to incl. medications): No Yes Please list if answered yes: _____

SECTION C

PLEASE READ AND INITIAL EACH SECTION BELOW

Student Observers

_____ I understand and acknowledge, by signing this document, that FSU Student Health and Wellness Center, as part of Florida State University, may have students from healthcare majors (i.e., College of Nursing, College of Medicine, College of Human Sciences) as observers during the course of my visit at UHS. I further understand that the UHS staff members will inform me when a student is observing my care. I give UHS permission to allow a student observer and I understand that I may at any time, decline to have a student observer during the course of my care at UHS.

Notice of Privacy Policy

_____ I acknowledge, by my signature below that I have received a copy of the FSU Student Health and Wellness Center Notice of Privacy Practices, included in this packet as Form 4, as required by Federal Regulations.

Consent to Treat

I authorize FSU Student Health and Wellness Center, its agents (i.e., College of Medicine, College of Nursing, Medical Response Unit) and employees, to provide and perform such care, procedures, tests, and other services as are considered advisable by my clinician for my health and well-being. I acknowledge that no guarantees have been made to me as to the effect of such examinations, procedures, and treatment of any condition.

Student Signature _____ **Date:** _____

REQUIRED AUTHORIZATION FOR CARE OF STUDENTS UNDER AGE 18: I CONCUR WITH THE ABOVE AND AUTHORIZE, AT THE DISCRETION OF HEALTH CENTER PERSONNEL, MEDICAL AND SURGICAL CARE INCLUDING EXAMINATIONS, TREATMENTS, IMMUNIZATIONS AND THE LIKE FOR MY SON/DAUGHTER. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable effort will be made to contact me but the failure to make contact will not prevent emergency treatment if necessary to help preserve life or health.

Parent / Guardian signature _____ Date: _____