SOUTHEASTERN UNIVERSITY

MEDICAL HEALTH HISTORY

Full Name: ____ SEU ID#: _____________________

Age: _________ Birthdate: _______________ Date of last physical exam: ___________________

Primary Physician: __________________________________ Phone #: _____________________

Emergency Contact Name: __________________________ Relationship: ______________________

Home Phone#: _______________ Work Phone #: ______________ Cell Phone #: ________________

MEDICATIONS: List all the medications you are currently taking.

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ALLERGIES: List all allergies to medications or substances.

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CONDITIONS: List any medical conditions you currently have or have had in the past year.

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I certify that the above information is correct to the best of my knowledge. I will not hold Southeastern University or any faculty or staff member responsible for any errors or omissions that I may have made in the completion of this Medical Health History Form.

____ _________________________

Signature Date

Please attach a copy of your immunization record to this form
and submit both to Director of Jerusalem Studies, Cedrick Valrie, Spence Lobby, Room 1.