

Student ID Number: _____

List all medications that you are currently taking, along with dosage and purpose. If necessary, continue on the back of this form.

List and thoroughly explain any physical limitations.

List and explain any medical conditions that exist among your family members.

If you have had any of the following medical conditions, please indicate and include a detailed explanation. If necessary, continue on the back of this form.

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergic Reactions? | <input type="checkbox"/> Epilepsy? | <input type="checkbox"/> Menstrual Disorders? |
| <input type="checkbox"/> Asthma? | <input type="checkbox"/> Hormonal Problem? | <input type="checkbox"/> Stomach or Bowel problem? |
| <input type="checkbox"/> Cancer? | <input type="checkbox"/> Mental Health Problem? | <input type="checkbox"/> Kidney Disease? |
| <input type="checkbox"/> Serious Injury? | <input type="checkbox"/> Heart Problem? | <input type="checkbox"/> Surgical Procedures? |
| <input type="checkbox"/> Diabetes? | <input type="checkbox"/> Eye Problems? | <input type="checkbox"/> Bleeding Disorder? |
| <input type="checkbox"/> Hearing Problem? | <input type="checkbox"/> Learning disability? | <input type="checkbox"/> Thyroid Disease? |
| <input type="checkbox"/> Eating Disorder? | <input type="checkbox"/> Liver Disease? | <input type="checkbox"/> Other? |

Please list any other information that may be pertinent to the student's health while attending SVU.

Please note that Southern Virginia University requires a copy of your complete immunization records. Please include the student name and ID # on all records. The immunization records can be returned with this form.



**SOUTHERN
VIRGINIA
UNIVERSITY**

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