

Health Record

All information is confidential and is placed in your Personal Health Record. Please complete and return by July 1.



PERSONAL INFORMATION (Print all information)

Name Last First Middle Date

Home Address Street Address City State Zip

Parents' Phone () Student's Phone ()

Date of Birth Place of Birth

Name of Parent or Legal Guardian

Address Street Address City State Zip

Phone (Day) () (Evening) () (If different from above)

Emergency Notification (Name) (If different from above)

Phone (Day) () (Evening) () Relationship (If different from above)

FAMILY HISTORY (REQUIRED)

Have any of your relatives ever had any of the following? (Check if yes.)

- YES RELATIONSHIP YES RELATIONSHIP
Tuberculosis Diabetes Kidney Disease (kind) Heart Disease (kind) Arthritis (kind) Stomach Disease (kind) Asthma
Epilepsy, Convulsion High Blood Pressure Stroke Migraines Cancer (kind) Blood Disease (kind)

Table with 4 columns: Age, State of Health, Age at Death, Cause of Death. Rows for Father, Mother, Siblings.

PERSONAL HISTORY (REQUIRED)

Indicate if you have or have ever had any of the following conditions: (Check if yes.)

- Adrenal Condition Altitude Sickness Anemia Anxiety Asthma Back/Neck Problem Bladder Infection Cancer/Tumor/Leukemia Chest Pain Chicken Pox Deafness/Hearing Loss Depression Diabetes Digestive Problems Dizziness
Drug/Alcohol Dependency Eating Disorder Fainting/Passing Out Frostbite Head Injury/Concussion Heart Disease Heart Murmur Heart Rhythm Problem Hepatitis/Liver Disease Hernia High Blood Pressure HIV/AIDS Hyperventilation Hypothermia Insomnia
Joint or Bone Disease Kidney Disease/Stone Malaria Measles (Rubeola) Migraine Headache Mononucleosis Mumps Phlebitis Polio Rheumatic Fever Rubella (German Measles) Seizures/Epilepsy Sickle Cell Anemia Skin Problems
Stomach Ulcer/GERD Stroke Suicide Attempt Sun Sensitivity Sunstroke/Heat Exhaustion Thyroid Condition Tonsillectomy Tuberculosis

List Surgeries

Please answer the following. You may use an additional sheet of paper if necessary.

1. Please provide detailed information on all positive responses about your personal history from the previous page. Indicate, also, when the medical condition or symptom occurred and if the condition is current.

2. Please describe any other illness, medical problem, hospitalization, or surgery not identified on the previous page, including when it occurred and if the condition is current.

3. Are you allergic to any medications? If yes, what medication(s) and what is your reaction?

4. Are there any other medications you have been told to avoid? If yes, what medication(s) and why?

5. List any medications you are using, including psychiatric and over-the-counter medication.

Medication	Condition	Dosage (size & frequency)	Current Side Effects
------------	-----------	---------------------------	----------------------

6. Are you allergic to dust, molds, pollens, insect stings? yes no If yes, what? Explain the severity and means of treatment.

7. Have you any food allergies or other dietary restrictions? yes no If yes, what?

(If you have food allergies, direct any questions you might have to the Food Service Director when you arrive on campus.)

8. Have you lived or traveled overseas? yes no Where? When? _____

9. Has your physical activity been restricted during the past 5 years, including your ability to run, lift and climb? Is it now restricted? Give details, including the reason and duration. _____

10. Do you wear glasses or contact lenses? yes no Which, and for what reason? _____

11. Have you ever been under the care of a psychologist, psychiatrist, or counselor? yes no

If yes, when? _____ For what reason? _____

12. Please evaluate your general health by circling one: Excellent Good Fair Poor

13. Is there anything else about you that you would like us to know in order to provide for your health care? _____

Personal Physician _____ Phone _____

Personal Dentist _____ Phone _____

Personal Counselor/Psychiatrist Name _____ Phone _____

STATEMENT OF AUTHORIZATION

I authorize Earlham College Health Services to administer medical and surgical services including immunization, allergy injection, and to perform emergency procedures, as necessary, or refer to duly licensed medical personnel when indicated (including transfer to local hospitals). I authorize emergency medical treatment while participating on off campus programs. I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics unless otherwise noted in this health inventory.

Signature of student if 18 or over

Signature of parent/guardian (if under legal age of 18)

EARLHAM COLLEGE IMMUNIZATION RECORD

This immunization record form must be completed before coming to the Earlham College. All information to be completed in English and signed by Health Care Professional. The following immunizations and tuberculosis testing is required for all students attending Earlham College. Do not write see attached please. If you have any questions, call Health Services at 765 983-1328 or email

Name _____
Last First Middle

REQUIRED IMMUNIZATIONS

•MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at 12 months or later #1 ____/____/____ Dose 2 given at least 28 days after first dose. #2 ____/____/____
M D Y M D Y

•MENINGOCOCCAL QUADRIVALENT (ACWY)

1. Quadrivalent conjugate

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ if only one dose, then must be after 16 years of age
M D Y M D Y

•SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____
M D Y M D Y

OR

2. MenB-FHbp (Trumenba)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
M D Y M D Y M D Y

•TETANUS, DIPHTHERIA, PERTUSSIS

1.Primary series completed? Yes ____ No ____ Date of last dose in series: ____/____/____
M D Y

2.Date of most recent booster dose: ____/____/____ Type of booster: Td ____ Tdap ____
M D Y

•HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____
M D Y M D Y

•HEPATITIS B

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
M D Y M D Y M D Y

Adult formulation ____ Child formulation ____

Adult formulation ____ Child formulation ____

Adult formulation ____ Child formulation ____

HepB-CpG (Heplisav-B) ____

HepB-CpG (Heplisav-B) ____ HepB-CpG (Heplisav-B) ____

•VARICELLA

a. Dose #1 ____/____/____ #2 ____/____/____ Dose #2 given at least 12 weeks after first dose ages 1-12 years.
and at least 4 weeks after first dose if age 13 years or older.

History of Disease Yes ____ date _____ No ____ or Birth in U.S. before 1980 Yes ____ No ____

•POLIO

1. OPV alone (oral Sabin three doses): #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
M D Y M D Y M D Y

2. IPV/OPV sequential: IPV #1 ___/___/___ M D Y IPV #2 ___/___/___ M D Y OPV #3 ___/___/___ M D Y
 OPV #4 ___/___/___ M D Y

3. IPV alone (injected Salk four doses): #1 ___/___/___ M D Y #2 ___/___/___ M D Y
 #3 ___/___/___ M D Y #4 ___/___/___ M D Y

TUBERCULOSIS (TB) TESTING is required of all students. TB skin test within the last 6 months or Quantiferon testing.

Quantiferon TB test Negative ___/___/___ M D Y Positive ___/___/___ M D Y

TB skin test Negative ___/___/___ M D Y Positive ___/___/___ M D Y _____MM Induration

Chest x-ray required if TB skin test greater than 10 mm induration or quantiferon positive.

X-ray results Normal _____ Abnormal _____ Date ___/___/___ M D Y

Please attach x-ray results and record of treatment if Quantiferon or TB test is positive.

RECOMMENDED VACCINATIONS

HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) _____ or 9-valent (HPV9) _____
 a. Dose #1 ___/___/___ M D Y b. Dose #2 ___/___/___ M D Y c. Dose #3 ___/___/___ M D Y

PNEUMOCOCCAL POLYSACCHARIDE VACCINE

PCV 13 _____ Date ___/___/___ PPSV 23 _____ Date ___/___/___

HEALTH CARE PROVIDER INFORMATION

Name _____ Signature _____

Address _____ Phone (_____) _____

All Students are required to have **insurance** that provides **coverage in Indiana**. Please attach a copy of your insurance and/or prescription card(s), front and back. Students are responsible for submitting all insurance claims. Earlham College Health Services does not submit to insurance directly but students will receive statements to turn into their insurance.

Please return the completed health record to:
 Health Services
 Earlham College
 801 National Road West
 Richmond, IN 47374-4095
 765-983-1328 FAX: 765-983-1488

For questions, please call 765-983-1328 or email wuertka@earlham.edu.

Earlham College reaffirms its commitment, in all its activities and processes, to treat all people equally, without concern for age, gender, sexual orientation, race, nationality or ethnic origin.