Health Record

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

Earlham COLLEGE

PERSONAL INFORMATION (Print all information)

Name _____ Date _____
Last First Middle

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) (If different from above)

Emergency Notification (Name) _____
(If different from above)

Phone (Day) (_____) _____ (Evening) (_____) _____ Relationship _____
(If different from above) (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*	_____	☐ Epilepsy, Convulsion	_____
☐ Diabetes	_____	☐ High Blood Pressure	_____
☐ Kidney Disease (kind)	_____	☐ Stroke	_____
☐ Heart Disease (kind)	_____	☐ Migraines	_____
☐ Arthritis (kind)	_____	☐ Cancer (kind)	_____
☐ Stomach Disease (kind)	_____	☐ Blood Disease (kind)	_____
☐ Asthma	_____		

* Please read Quantiferon Testing Policy at:
earlham.edu/media/4227843/quantiferon-testing-policy.pdf

	Age	State of Health	Age at Death	Cause of Death
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 — Meningitis B series is required for students age up to 23 years of age.

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 _____/_____/_____ IPV #2 _____/_____/_____ OPV #3 _____/_____/_____
M D Y M D Y M D Y

OPV #4 _____/_____/_____
M D Y

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

#3 _____/_____/_____ #4 _____/_____/_____
M D Y M D Y

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

Quaniferon TB test Negative ____/____/_____ Positive ____/____/_____
M D Y M D Y

TB skin test Negative ____/____/_____ Positive____/____/_____ _____MM Induration
M D Y M D Y

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 _____/_____/_____ b. Dose #2 _____/_____/_____ c. Dose #3 _____/_____/_____
M D Y M D Y 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.