

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 _____ Date _____
Last First Middle

Home Address _____
Street Address City State Zip

Parents' Phone (_____) _____ Student's Phone (_____) _____

Date of Birth (Date/Month/Year) _____ Place of Birth _____

Name of Parent or Legal Guardian _____

Address _____
(If different from above) 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) (If different from above)

REQUIRED: FAMILY HISTORY

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

YES	RELATIONSHIP	YES	RELATIONSHIP
<input type="checkbox"/> Tuberculosis _____		<input type="checkbox"/> Epilepsy, Convulsion _____	
<input type="checkbox"/> Diabetes _____		<input type="checkbox"/> High Blood Pressure _____	
<input type="checkbox"/> Kidney Disease (kind) _____		<input type="checkbox"/> Stroke _____	
<input type="checkbox"/> Heart Disease (kind) _____		<input type="checkbox"/> Migraines _____	
<input type="checkbox"/> Arthritis (kind) _____		<input type="checkbox"/> Cancer (kind) _____	
<input type="checkbox"/> Stomach Disease (kind) _____		<input type="checkbox"/> Blood Disease (kind) _____	
<input type="checkbox"/> Asthma _____			

	Age	State of Health	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

REQUIRED: PERSONAL HISTORY

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

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

You may use an additional sheet of paper in answering any of the questions below.

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
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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? If yes, what?

(If you have food allergies, you are encouraged to 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? _____ (nearsighted, etc?)

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: 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 _____ Telephone _____

Personal Dentist _____ Telephone _____

Personal Counselor/Psychiatrist Name _____ Telephone _____

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)

Name _____ Date of Entry _____ Date of Birth _____

Written documentation of immunizations and TB test must be completed prior to arrival on campus. **Do NOT write "see attached."**
(All information must be in English).

REQUIRED

• **Measles, Mumps, Rubella (MMR)**

2 doses:

#1 On or after 1st birthday ____/____ (Mo/Yr)

#2 Grade school entry or later ____/____ (Mo/Yr)

• **Tetanus/Diphtheria (Td or Tdap)**

Booster dose within the **last 10 years**

(Within **last 5 years** for Wilderness or

Off Campus Programs): ____/____ (Mo/Yr)

• **Meningitis (MCV4)**

Meningococcal Vaccine **within last five years**

____/____ (Mo/Yr)

REQUIRED

• **Tuberculosis (TB)**

Tuberculosis Test is required of all **within the past six (6) months**, including those who have had BCG inoculation.

If you have had BCG, Quantiferon-TB test:

Negative: ____/____ (Mo/Yr)

Positive: ____/____ (Mo/Yr)

If you have **NOT** had BCG, TB Skin Test or Quantiferon-TB:

Negative: ____/____ (Mo/Yr)

Positive: ____/____ (Mo/Yr)

MM Induration: _____

Chest x-ray required if greater than 10 mm

X-ray result:

Normal: ____/____ (Mo/Yr)

Abnormal: ____/____ (Mo/Yr)

(attach copy and record of any treatment)

RECOMMENDED

Hepatitis A:

#1 ____/____ (Mo/Yr)

#2 ____/____ (Mo/Yr)

Hepatitis B:

#1 ____/____ (Mo/Yr)

#2 ____/____ (Mo/Yr)

#3 ____/____ (Mo/Yr)

OTHER

Polio: Completed primary series of polio immunization: Yes No

Date of Adult Booster: ____/____ (Mo/Yr) Vaccine Type _____

Varicella (Chickenpox):

Diagnosis of disease: Yes No Vaccinated #1 ____/____ (Mo/Yr) Vaccinated #2 ____/____ (Mo/Yr)

Gardasil: #1 ____/____ (Mo/Yr) #2 ____/____ (Mo/Yr) #3 ____/____ (Mo/Yr)

Sources of Requirements & Recommendations: Indiana State Department of Health - I.C. 20-12-71; Advisory Committee on Immunization Practices (ACIP); and American College Health Association

HEALTH CARE PROVIDER

Name _____ Credentials _____

Address _____

Phone _____

I have verified the accuracy of the above information: _____

Signature

Date

Insurance Information

All students are required to have insurance that provides coverage in Indiana. Please attach a copy of your insurance and prescription cards, front and back. Make sure your student arrives on campus with the card. The student is responsible for filing all insurance claims.

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

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.