EARLHAM COLLEGE

HEALTH RECORD

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

SECTION A · PERSONAL INFORMATION

Please print or type all information.

Student Name (Last, First, Middle initial)

Birthdate (mm/dd/yy)

Street Address

City

State

Zipcode

Place of Birth

Student's Phone Number

Name of Parent or Legal Guardian

Relationship

Street Address

City

State

Zipcode

Daytime Phone

Evening Phone (if different than daytime)

Emergency Notification Name (if different from above)

SECTION B · FAMILY HISTORY

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

Ailment	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)	
○ Other _____	

Relationship	Age	State of Health *(excellent, good, fair, poor)*	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Other: _____				
_____				
_____				

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

Earlham College
HEALTH SERVICES

Please return the completed health record to:

Health Services
801 National Road West
Richmond, Indiana 47374

765-983-1328
FAX: 765-983-1488
healthservices@earlham.edu

EARLHAM COLLEGE

HEALTH RECORD

SECTION C · PERSONAL HISTORY

Add a check mark if you have or have ever had any of the following conditions:

Ailment

- ○ 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
- ○ Other

_____

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 in section C. Also, please indicate 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 medication(s)? If yes, what medication(s) and what is your reaction?

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

5. List any medication(s) you are using, including psychiatric and over-the-counter medication, noting condition, dosage & current side effects.

6. Are you allergic to dust, molds, pollens or 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? Explain the severity and means of treatment.

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

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HEALTH RECORD

8. Have you lived or traveled overseas?
   ○ Yes ○ No

   If yes, where and when?

9. Has your physical activity been restricted during the past 5 years, including your ability to run, lift and climb?
   ○ Yes ○ No

   If yes, give details,including the reason and duration.

10. Do you wear glasses or contact lenses?
    ○ Yes ○ No

    If yes, which and for what reason?

11. Have you ever been under the care of a psychologist, psychiatrist or counselor?
    ○ Yes ○ No

    If yes, when and for what reason?

12. Please evaluate your general health by checking one.
    ○ Excellent ○ Good ○ Fair ○ Poor

    Is there anything else you would like us to know in order to receive health care?

Personal Physician | Phone

Personal Dentist | Phone

Personal Counselor/Psychiatrist Name | Phone

SECTION D · STATEMENT OF AUTHORIZATION

I authorize Earlham College Health Services to administer medical and surgical services including immunization, injections, 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 in 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.

Student Signature | Date

Parent/Guardian Signature (if under age of 18) | Date

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HEALTH RECORD

SECTION E · 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 a 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 **healthservices@earlham.edu**

REQUIRED IMMUNIZATIONS

MMR (Measles, mumps, rubella)

Dose 1 date given at 12 months or later: _____ Dose 2 date given at least 28 days after first dose: _____

Meningococcal Quadrivalent (ACWY)

Dose 1 date: _____ Dose 2 date: _____ *If only one dose, then must be after 16 years of age.*

Serogroup B Meningococcal

Meningitis B series is required for students up to 23 years of age. The vaccine series must be completed with the same vaccine.

◯ MenB-RC (Bexsero)

Dose 1 date: _____ Dose 2 date: _____

or

◯ MenB-FHbp (Trumenba)

Dose 1 date: _____ Dose 2 date: _____ Dose 3 date: _____

Tetanus, Diphtheria, Pertussis

Primary series completed? ◯ Yes ◯ No

Date of last dose in series: _____

Date of last booster: _____

Type of booster: ◯ Td ◯ Tdap

Hepatitis A

Dose 1 date: _____ Dose 2 date: _____

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.

Dose 1 date: _____ Dose 2 date: _____ Dose 3 date: _____

◯ Adult formulation
◯ Child formulation
◯ HepB-CpG (Heplisav-B)

◯ Adult formulation
◯ Child formulation
◯ HepB-CpG (Heplisav-B)

◯ Adult formulation
◯ Child formulation
◯ HepB-CpG (Heplisav-B)

Varicella

Dose 1 date: _____ Dose 2 date: _____ *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

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Polio

○ OPV alone (oral Sabin three doses):

Dose 1 date: Dose 2 date: Dose 3 date:

○ IPV/OPV sequential:

IPV 1 date: IPV 2 date: OPV 3 date: OPV 4 date:

○ IPV alone (injected Salk four doses):

Dose 1 date: Dose 2 date: Dose 3 date: Dose 4 date:

Tuberculosis (TB) Testing

The TB test is required of all students (TB skin test within the last 6 months or Quantiferon testing).
Please attach x-ray results and record of treatment if Quantiferon or TB test is positive.

○ Quaniferon TB test

Negative date: Positive date:

○ TB skin test

Negative date: Positive date: MM Induration

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

○ Normal ○ Abnormal Date:

RECOMMENDED IMMUNIZATIONS

Human Papillomavirus Vaccine

Immunization (indicate which preparation, if known) ○ Quadrivalent (HPV4) ○ 9-valent (HPV9)

Dose 1 date: Dose 2 date:

Pneumococcal Polysaccharide Vaccine

○ PCV 13 Date: ○ PPSV 23 Date:

HEALTHCARE PROVIDER INFORMATION

Name Phone

Address Signature

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