



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)	
<input type="text"/>			<input type="text"/>	
Street Address		City	State	Zipcode
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Place of Birth			Student's Phone Number	
<input type="text"/>			<input type="text"/>	
Name of Parent or Legal Guardian			Relationship	
<input type="text"/>			<input type="text"/>	
Street Address		City	State	Zipcode
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Daytime Phone	Evening Phone (if different than daytime)	Emergency Notification Name (if different from above)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

**SECTION B · FAMILY HISTORY**

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

Ailment	Relationship	Relationship	Age	State of Health <i>(excellent, good, fair, poor)</i>	Age at Death	Cause of Death
<input type="radio"/> Tuberculosis*	<input type="text"/>	Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Diabetes	<input type="text"/>	Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Kidney Disease (kind)	<input type="text"/>	Siblings	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Heart Disease (kind)	<input type="text"/>	Other:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Arthritis (kind)	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Stomach Disease (kind)	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Asthma	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Epilepsy, Convulsion	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> High Blood Pressure	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Stroke	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Migraines	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Cancer (kind)	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Blood Disease (kind)	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Other	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

\* Please read Quantiferon Testing Policy at: [earlham.edu/media/4227843/quantiferon-testing-policy.pdf](http://earlham.edu/media/4227843/quantiferon-testing-policy.pdf)



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**SECTION C · PERSONAL HISTORY**

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

**Ailment**

- |   |   |  |   |
|---|---|--|---|
| <input type="radio"/> Adrenal Condition     | <input type="radio"/> Drug/Alcohol Dependency | <input type="radio"/> Joint or Bone Disease    | <input type="radio"/> Stroke  |
| <input type="radio"/> Altitude Sickness     | <input type="radio"/> Eating Disorder         | <input type="radio"/> Kidney Disease/Stone     | <input type="radio"/> Suicide Attempt                                   |
| <input type="radio"/> Anemia                | <input type="radio"/> Fainting/Passing Out    | <input type="radio"/> Malaria                  | <input type="radio"/> Sun Sensitivity                                   |
| <input type="radio"/> Anxiety               | <input type="radio"/> Frostbite               | <input type="radio"/> Measles (Rubeola)        | <input type="radio"/> Sunstroke/Heat Exhaustion                         |
| <input type="radio"/> Asthma                | <input type="radio"/> Head Injury/Concussion  | <input type="radio"/> Migraine Headache        | <input type="radio"/> Thyroid Condition                                 |
| <input type="radio"/> Back/Neck Problem     | <input type="radio"/> Heart Disease           | <input type="radio"/> Mononucleosis            | <input type="radio"/> Tonsillectomy                                     |
| <input type="radio"/> Bladder Infection     | <input type="radio"/> Heart Murmur            | <input type="radio"/> Mumps                    | <input type="radio"/> Tuberculosis                                      |
| <input type="radio"/> Cancer/Tumor/Leukemia | <input type="radio"/> Heart Rhythm Problem    | <input type="radio"/> Phlebitis                | <input type="radio"/> Other   |
| <input type="radio"/> Chest Pain            | <input type="radio"/> Hepatitis/Liver Disease | <input type="radio"/> Polio                    |   |
| <input type="radio"/> Chicken Pox           | <input type="radio"/> Hernia                  | <input type="radio"/> Rheumatic Fever          |   |
| <input type="radio"/> Deafness/Hearing Loss | <input type="radio"/> High Blood Pressure     | <input type="radio"/> Rubella (German Measles) | <b>List surgeries</b>   |
| <input type="radio"/> Depression            | <input type="radio"/> HIV/AIDS                | <input type="radio"/> Seizures/Epilepsy        | <div style="border: 1px solid black; height: 50px; width: 100%;"></div> |
| <input type="radio"/> Diabetes              | <input type="radio"/> Hyperventilation        | <input type="radio"/> Sickle Cell Anemia       |   |
| <input type="radio"/> Digestive Problems    | <input type="radio"/> Hypothermia             | <input type="radio"/> Skin Problems            |   |
| <input type="radio"/> Dizziness             | <input type="radio"/> Insomnia                | <input type="radio"/> Stomach Ulcer/GERD       |   |

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

- 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.

- 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.

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

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

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

- Are you allergic to dust, molds, pollens or insect stings?

Yes    No

If yes, what? Explain the severity and means of treatment.

- 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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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, 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 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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**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](mailto: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 #2.

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

- |   |   |   |
|---|---|---|
| <input type="radio"/> Adult formulation     | <input type="radio"/> Adult formulation     | <input type="radio"/> Adult formulation     |
| <input type="radio"/> Child formulation     | <input type="radio"/> Child formulation     | <input type="radio"/> Child formulation     |
| <input type="radio"/> HepB-CpG (Heplisav-B) | <input type="radio"/> HepB-CpG (Heplisav-B) | <input type="radio"/> HepB-CpG (Heplisav-B) |



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**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:  **or** Birth in U.S. before 1980?  
 No  Yes  No

**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.

I have received the BCG (Bacille Calmette-Guerin) Vaccination:

Yes Date of vaccination:   No

QuantiFERON TB test (See QuantiFERON Testing Policy)

Negative date:  Positive date:

TB skin test

Negative date:  Positive date:  MM Induration

*Chest x-ray required if QuantiFERON or TB skin test positive (must be less than 6 months ago)*

Normal Date:

Abnormal Date:



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**RECOMMENDED IMMUNIZATIONS**

●  
**Human Papillomavirus Vaccine**

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

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

**Pneumococcal Polysaccharide Vaccine**

PCV 13 Date:   PPSV 23 Date:

**HEALTHCARE PROVIDER INFORMATION**

Name  Phone

Address  Signature