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	Birthdate

Street address	City	State	Zipcode

Place of birth	Students' 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)	

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

** 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

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

Ailment

- Adrenal Condition
- 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
- Head Injury/Concussion
- Heart Disease
- Heart Murmur
- Heart Rhythm Problem
- Hepatitis/Liver Disease
- Hernia
- High Blood Pressure
- HIV/AIDS
- Insomnia
- Joint or Bone Disease
- Kidney Disease/Stone
- Malaria
- Measles (Rubeola)
- Migraine Headache
- Mononucleosis
- Mumps
- Polio
- Rheumatic Fever
- Rubella (German Measles)
- Seizures/Epilepsy
- Sickle Cell Anemia
- Skin Problems
- Stomach Ulcer/GERD
- Stroke
- Suicide Attempt
- 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, diagnosis (physical or mental health related), 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, noting condition, dosage, and 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? 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 provide health care?

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 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.

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

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