HEALTH RECORD

Earlham COLLEGE

All information is confidential and is placed in your Personal Health Record
Please return the completed health record in the enclosed envelope marked "Health Form."

PERSONAL INFORMATION (PRINT ALL INFORMATION)

Name _____ Date _____
Last First Middle

Social Security Number _____ ☐ Male ☐ Female

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 _____
(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
☐ 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			

	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.)

- ☐ 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:

_____

_____

_____

_____

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

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/Diptheria (Td or Tdap)**
  Booster dose within the **last 10 years**
  (Within **last 5 years** for Wilderness or
  Off Campus Programs): ____/____ (Mo/Yr)
- **Meningitis (MCV4)**
  Meningoccocal Vaccine **within last five years**
  ____/____ (Mo/Yr)

REQUIRED

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

Name _____ Date of Birth _____

Physician Physical – Required Only For *Wilderness Programs or Participation in Athletics

Sex: ☐ Male ☐ Female Height _____ inches Weight _____ lbs

Corrected Vision: Right 20/_____ Left 20/_____ Color Vision: ☐ Normal ☐ Abnormal

Blood Pressure (sitting): Right Arm _____ Left Arm _____ Pulse (resting) _____

Required for Females: HGB: _____ Gm. OR HCT _____%

Urinalysis: ☐ Normal Abnormalities: ☐ Sugar ☐ Albumin ☐ Micro

Are there irregularities of the following systems:

	Normal	Abnormal	
Head/Ear. Nose or Throat	☐	☐	_____
Eyes (other than acuity)	☐	☐	_____
Endocrine	☐	☐	_____
Respiratory	☐	☐	_____
Hernia	☐	☐	_____
Neuropsychiatric	☐	☐	_____
Cardiovascular	☐	☐	_____
Skin/Teeth	☐	☐	_____
Gastrointestinal	☐	☐	_____
Musculoskeletal	☐	☐	_____

Weight loss or gain of > 10 pounds in last year ☐ Yes ☐ No

Is there loss or seriously impaired function of any paired organ? ☐ Yes ☐ No

Is the student now under treatment or do you recommend care for any physical or emotional problem? ☐ Yes ☐ No

Recommendations for physical activity, intercollegiate athletics, physical education, Wilderness*.

☐ **Limited** ☐ **Unlimited**

Explain limitations: _____

_____

_____

Physician Signature _____ Date _____

Print Name _____ Telephone _____

Address _____

Street *City* *State* *Zip*

**Summer Wilderness programs range from one to three weeks in duration and typically take place in remote areas which can be far from definitive medical care. Activities may include lifting and carrying heavy canoes or packs (50+ lbs.), travel above 12,000 feet, and periods of sustained physical exertion. A college student in reasonable physical and mental condition can be expected to complete the program successfully.*

STUDENT

The information provided is correct.
Health Services may copy this record and send it to the Wilderness Coordinator if I enroll in a Wilderness Program at Earlham.
Health Services may provide information contained in the physician physical portion of this form and the date of my last tetanus immunization to the athletic trainer for any athletic sport I join that requires a physician physical for participation.

Student Signature _____ Date _____

Please return the completed health record to:
Earlham College Health Services
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.