Sterling College
Working Hands. Working Minds.

Personal Health History Form

Please Note: BOTH the **Personal Health History Form** and **Physical Examination Form / Certificate of Immunization** (completed by a health care provider – MD, NP, or PA) must be completed and returned to Sterling College before you begin classes. You will not be allowed to participate in activities or classes until this form is on file.

The purpose of this form is to identify specific health history concerns to enable us to assure optimum health care for each student. **It is important to provide complete information. Failure to provide complete and accurate information about your health could result in an injury or compound the damage of an injury.**

Name: _____

DOB: _____ **Gender:** _____ **Pronoun:** _____

Emergency Contact Name: _____
(if under 17, must be a parent or guardian)

Phone: _____

Emergency Contact Name: _____

Phone: _____

Health Insurance Carrier: _____

Policy and Group #: _____
Please include copy of card

Check if you have ever had or are currently being treated for the following:

- ❑ Frequent or severe headaches
- ❑ Dizzy spells, fainting, blackouts
- ❑ Joint or bone deformity/fracture
- ❑ Malaria, dysentery, or tropical disease
- ❑ Seizures
- ❑ Heart problems
- ❑ Vision problems
- ❑ Hearing problems
- ❑ Asthma
- ❑ Diabetes
- ❑ Anemia
- ❑ Back injury
- ❑ Eating disorder
- ❑ Traumatic Brain Injury
- ❑ Post-Traumatic Stress Disorder
- ❑ Knee or joint problems
- ❑ Immunity problems
- ❑ Anxiety or Depression
- ❑ Other diseases, diagnoses, or injuries:

_____

_____

Please explain any checked boxes (severity, dates, therapies, medications, etc.):

_____

ALLERGIES: include medicines, foods, bites and stings etc. **None**: _____ (check)

Allergy	Reactions	Medication Required

If you have known anaphylactic reaction to any substance you must have your own epinephrine pen and carry it with you at all times.

MEDICATIONS: prescription **and** over the counter **None**: _____ (check)

Medication	Condition	Dosage (amount & freq)	Current side effects

If medication taken "as needed", indicate date of last dosage: _____

Have you ever had surgery? **Yes No** If yes, please list the types and dates:

_____

_____

Have you ever had psychological counseling? **Yes No** If yes, please explain:

_____

_____

Are you currently seeing a counselor? **Yes No**

Is there any other information you would like to share about your well-being?

_____

_____

Authorization Release: The medical history is correct to the best of my knowledge. I understand that failure to provide complete and accurate information about my health could result in an injury or compound the damage of an injury. I am physically and mentally able to engage in all prescribed Sterling College activities, except as noted by the examining health care provider and me.

If in the event of an emergency, I am unable to give permission and my guardian is unable to be reached, I hereby give my permission to the Wellness Center Staff of Sterling College or designated representative, upon consultation with a practicing physician, to secure appropriate medical and/or psychiatric treatments, which may include hospitalization.

Student Signature: _____ Date: _____

Parent or guardian must sign if the student has not yet reached 18 years of age.

Parent/Guardian Signature: _____ Date: _____