

Health History Record

Parsons Student Health Center
Centre College
600 W. Walnut St., Danville, KY 40422-1394

CONFIDENTIAL

Must be completed and
returned before July 15

Date _____

Class _____

Please Print

Name _____
Last Name First Name Middle Name Nickname

Address _____
Street Address City State Zip Code

Date of Birth _____ Social Security # _____
Month Day Year

Persons to be notified in an emergency:

Name _____ Home phone () _____ Bus. Phone () _____

Name _____ Home phone () _____ Bus. Phone () _____

Personal Physician _____ Phone () _____

HEALTH INSURANCE INFORMATION

Submit copy of both sides of insurance card

Name of Ins. Co. _____ Subscriber's ID No. _____ Grp. No. _____

Address of Ins. Co. _____ Subscriber's Name _____

If preadmission certification required, give phone number to call () _____

Is Ephraim McDowell Regional Medical Center covered under your insurance policy? Yes No

ALLERGIES

Please list

To Medication _____ Food _____

Bee Sting _____ Other _____ Do you carry an Epi Pen? _____

Have you or are you now taking allergy shots? _____

If you are currently taking allergy shots, please have your physician send pertinent information to us so that we can continue to give your allergy injections.

MEDICATIONS

Current medications, including dosage _____

PERSONAL HISTORY

Have you ever had or do you now have any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|--------------------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Alcoholism or chemical dependency... | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Painful menstruation..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia or other blood disease..... | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis..... | <input type="checkbox"/> | <input type="checkbox"/> | Skin disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone or joint disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Stomach trouble, intestinal disease, or ulcer... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> | Major trauma, multiple injuries..... | <input type="checkbox"/> | <input type="checkbox"/> | Suicide attempt..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Chickenpox..... | <input type="checkbox"/> | <input type="checkbox"/> | Migraine headaches..... | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis..... | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a transfusion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Mononucleosis..... | <input type="checkbox"/> | <input type="checkbox"/> | Other serious illness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug or alcohol overdose..... | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment..... | <input type="checkbox"/> | <input type="checkbox"/> | Other medical problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear/nose/throat disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Psychological problems..... | <input type="checkbox"/> | <input type="checkbox"/> | Handicapping conditions..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | Psychological counseling..... | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Explanation of all YES answers _____

Name _____ Date of Birth _____

PERSONAL HISTORY

Do you have any physical handicaps or disabilities? Please explain. Yes No

In case of an emergency such as a fire, do you need special assistance to evacuate the building? Yes No

If you answered yes, do you give your permission to Parsons Student Health Center to share this information with your Resident Assistant (student Hall supervisor) and the Department of Public Safety? Yes No

Do you have an dietary restrictions? Please explain. Yes No

FAMILY HISTORY

| | Age | If Deceased, Age at Death | Cause of Death | Have any of your biological relatives ever had any of the following? | | | |
|----------|-------|------------------------------|----------------|--|--------------------------|--------------------------|-------|
| | | | | Yes | No | Relationship | |
| Father | _____ | _____ | _____ | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mother | _____ | _____ | _____ | Chemical Dependency (including Alcoholism) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Siblings | _____ | _____ | _____ | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | _____ | _____ | _____ | Epilepsy-Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | _____ | _____ | _____ | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | _____ | _____ | _____ | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | _____ | _____ | _____ | Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Please note: American College Health strongly recommends all students receive vaccines to prevent hepatitis B, HPV for women, meningitis, and varicella if indicated.

Documentation of immunization should include month and year. It is acceptable to attach a copy of your immunization certificate instead of filling in dates.

Proof of immunity requires documentation of the following: Two shots of measles containing vaccine (rubeola, MR, or MMR) 1st shot after the 1st birthday, 2nd shot anytime thereafter, and one of which must have been an MMR, or Positive titers to rubeola, rubella, and mumps (blood test), or Physician-diagnosed measles and mumps. History of german measles does not meet these requirements. A tetanus booster within the last 10 years is also required.

| | | | | | | | |
|-----------------|-----------------------|-------------------|-----------------------|------------|-----------------------|-----------------------|-----------------------|
| Vaccine | Date Given (mm/dd/yr) | Vaccine | Date Given (mm/dd/yr) | Vaccine | Date Given (mm/dd/yr) | Vaccine | Date Given (mm/dd/yr) |
| *MMR 1 | | Meningitis-circle | | DTP 1 | | OPV/IPV 4 | |
| Rubeola | | Menomune/Menactra | | DTP 2 | | Varicella Vaccine | |
| Rubella | | Hepatitis B | | DTP 3 | | History of chickenpox | |
| Mumps | | Hepatitis B | | DTP/DTaP 4 | | HPV | |
| *MMR 2 | | Hepatitis B | | OPV/IPV 1 | | HPV | |
| *Tetanus-circle | | Hepatitis A | | OPV/IPV 2 | | HPV | |
| TD/TdaP | | Hepatitis A | | OPV/IPV 3 | | Additional | |

***STUDENTS WILL NOT BE ALLOWED TO REGISTER FOR SECOND TERM WITHOUT THIS INFORMATION.**

Name _____ Date of Birth _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

All incoming students **MUST** complete the following screening questions:

Have you ever had a positive TB skin Test? Yes No If yes, what was the date __/__/__ result: ____mm induration

Was a chest x-ray performed? Yes No If yes, what was the date __/__/__ and result: _____

Did you receive any treatment? Yes No If yes, what was the treatment (with duration)_____

Have you ever had any close contact with anyone who was sick with TB? Yes No

Have you ever lived in any of the countries listed below? Yes No
(if yes, please CIRCLE the country/ies)

| | | | | |
|---------------------|-------------------|------------------|--------------------|-----------------------|
| Afghanistan | Congo | Japan | Namibia | Somalia |
| Algeria | Congo DR | Kazakhstan | Nauru | South Africa |
| Angola | Cote d'Ivoire | Kenya | Nepal | Spain |
| Anguilla | Croatia | Kiribati | New Caledonia | Sri Lanka |
| Argentina | Djibouti | Korea-DPR | Nicaragua | Sudan |
| Armenia | Dominican Rep. | Korea-Republic | Niger | Suriname |
| Azerbaijan | Ecuador | Kuwait | Nigeria | Syrian Arab Rep. |
| Bahamas | Egypt | Kyrgyzstan | Niue | Swaziland |
| Bahrain | El Salvador | Lao PDR | N. Mariana Islands | Tajikistan |
| Bangladesh | Equatorial Guinea | Latvia | Pakistan | Tanzania-UR |
| Belarus | Eritrea | Lesotho | Palau | Thailand |
| Belize | Estonia | Liberia | Panama | Timor-Leste |
| Benin | Ethiopia | Lithuania | Papua New Guinea | Togo |
| Bhutan | Fiji | Macedonia-TFYR | Paraguay | Tokelau |
| Bolivia | French Polynesia | Madagascar | Peru | Tonga |
| Bosnia Herzegovina | Gabon | Malawi | Philippines | Tunisia |
| Botswana | Gambia | Malaysia | Poland | Turkey |
| Brazil | Georgia | Maldives | Portugal | Turkmenistan |
| Brunei Darussalam | Ghana | Mali | Qatar | Tuvalu |
| Bulgaria | Guam | Marshall Islands | Romania | Uganda |
| Burkina Faso | Guatemala | Mauritania | Russian Federation | Ukraine |
| Burundi | Guinea | Mauritius | Rwanda | Uruguay |
| Cambodia | Guinea-Bissau | Mexico | St. Vincent & | Uzbekistan |
| Cameroon | Guyana | Micronesia | The Grenadines | Vanuatu |
| Cape Verde | Haiti | Moldova-Rep. | Sao Tome Principe | Venezuela |
| Central AfricanRep. | Honduras | Mongolia | Saudi Arabia | Viet Nam |
| Chad | India | Montenegro | Senegal | Wallis Futuna Islands |
| China | Indonesia | Morocco | Seychelles | W. Bank & Gaza Strip |
| Colombia | Iran | Mozambique | Sierra Leone | Yemen |
| Comoros | Iraq | Myanmar | Singapore | Zambia |
| | | | Solomon Islands | Zimbabwe |

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information visit www.acha.org.

Name _____ Date of Birth _____

REPORT OF PHYSICAL EXAMINATION

RECOMMENDED, NOT REQUIRED

To the examining physician: Please review the student's history and complete this section. **This student has been accepted to Centre College.** The information supplied will not affect that status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for use of the Health Services and will not be released without student consent.

| | |
|--------|----|
| Height | in |
| Weight | lb |

| |
|-------|
| B/P |
| Pulse |

| | |
|-------------------------|-------|
| CORRECTED VISION | |
| Right/20 | _____ |
| Left/20 | _____ |

After a general examination, please comment on the following:

Is there any seriously impaired function of any organ? Yes No

Is this student capable of participating in a full program of physical activity including competitive athletics? Yes No

Do you have any recommendations regarding the care of this student? Yes No

Is the patient under treatment for any medical or emotional condition? Yes No

Have you any general comments?

Please attach any lab results you feel are indicated.

| | | |
|-----------------------------|-----------------|------------|
| HEALTH CARE PROVIDER | | |
| Name _____ | Signature _____ | Date _____ |

AUTHORIZATION FOR MEDICAL CARE AND RELEASE OF INFORMATION

In order to promote access to medical care for students with medical illness, whether physical or emotional, each student eighteen (18) years of age (or over) or the custodial parent/guardian of each student under eighteen (18) years of age agrees as follows:

Be it known that I do hereby give and grant unto the Centre College school physicians and medical staff my consent to perform routine medical care through Parsons Student Health Center and necessary emergency care procedures and to use their own judgment in securing medical aid and/or emergency transportation. I understand that I am financially responsible for any and all medical expenses incurred.

Be it known also that I give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment, or care as may be required on an emergency basis, in the event that I should be stricken ill while under the supervision of Centre College personnel. This permission includes admission to a hospital, emergency surgery, administration of drugs, therapeutic procedures, etc., as deemed necessary by the attending physician.

I hereby authorize any physician or practitioner who has observed (student's name) _____ for diagnosis or treatment for any disease or ailment, and any hospital or clinic where I/she/he have or has been a patient for such diagnosis, treatment, disease, or ailment, to give full particulars thereof, upon request, to the Centre College Dean of Students in the case of potentially life threatening illness.

If I participate in intercollegiate athletics, I give my permission for a copy of this health history to be given for the treatment of illness to the Sports Medicine Physician. Additionally, if I am seen at Parsons Student Health Center I give my permission for necessary health information to be given to the Athletic Trainer if it would affect my participation.

I further give my permission to the Student Health Services to inform the Residence Life and Housing Office of pertinent health problems so my health may be maintained in an appropriate manner.

I also give my permission in an emergency for an employee of the college to transmit and otherwise disclose my medical records to the treating medical personnel.

A copy of this authorization shall be valid as the original and any copy and the original shall expire at the date the student graduates, or otherwise permanently ceases to be a student at Centre College.

Student: _____

Date: _____

Parent/Guardian: _____

Date: _____

Please be sure to read and sign the above authorization