

# Health Record

# EARLHAM

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 \_\_\_\_\_ Sex  Male  Female

Home Address \_\_\_\_\_  
Street Address City State Zip

Home Phone (Day) (\_\_\_\_\_) \_\_\_\_\_ (Evening) (\_\_\_\_\_) \_\_\_\_\_

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?

YES	RELATIONSHIP	Age	State of Health	Age at Death	Cause of Death
<input type="checkbox"/> Tuberculosis _____	Father	____	_____	____	_____
<input type="checkbox"/> Diabetes _____	Mother	____	_____	____	_____
<input type="checkbox"/> Kidney Disease (kind) _____	Siblings	____	_____	____	_____
<input type="checkbox"/> Heart Disease (kind) _____		____	_____	____	_____
<input type="checkbox"/> Arthritis (kind) _____		____	_____	____	_____
<input type="checkbox"/> Stomach Disease (kind) _____		____	_____	____	_____
<input type="checkbox"/> Asthma _____		____	_____	____	_____
<input type="checkbox"/> Epilepsy, Convulsion _____		____	_____	____	_____
<input type="checkbox"/> High Blood Pressure _____		____	_____	____	_____
<input type="checkbox"/> Stroke _____		____	_____	____	_____
<input type="checkbox"/> Migraines _____		____	_____	____	_____
<input type="checkbox"/> Cancer (kind) _____		____	_____	____	_____
<input type="checkbox"/> Blood Disease (kind) _____		____	_____	____	_____

## Required: Personal History

Indicate if you have or have ever had any of the following conditions:

<input type="checkbox"/> Adrenal Condition	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Rhythm Problem	<input type="checkbox"/> Measles (Rubeola)	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Altitude Sickness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Hernia	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sun Sensitivity
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug/Alcohol Dependency	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Sunstroke/Heat Exhaustion
<input type="checkbox"/> Back/Neck Problem	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Polio	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Fainting/Passing Out	<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer/Tumor/Leukemia	<input type="checkbox"/> Frostbite	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Rubella (German Measles)	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Joint or Bone Disease	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease/Stone	<input type="checkbox"/> Sickle Cell Anemia	
<input type="checkbox"/> Deafness/Hearing Loss	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Malaria	<input type="checkbox"/> Skin Problems	

**You may use an additional sheet of paper in answering any of the questions below.**

1. Please provide detailed information on all positive responses from the previous page. Indicate, also, when the medical condition or symptom occurred and if the condition is current.

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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.

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

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

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5. List any medications you are using, including psychiatric and over-the-counter medication.

Medication	Condition	Dosage (size & frequency)	Current Side Effects
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6. Are you allergic to dust, molds, pollens, insect stings?  yes  no If yes, what? Explain the severity and means of treatment.

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7. Have you any food allergies or other dietary restrictions?\* If yes, what?

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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.

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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\*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.

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)

# Earlham College Health Record

Name \_\_\_\_\_ Date of Entry \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Written documentation of immunizations and TB test must be completed and signed by health care provider.  
(All information must be in English).**

## REQUIRED

**Measles (Rubeola) Immunity** – must have one of the following:

1. **2 doses** live vaccine  
#1 on or after 1st birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ (Mo/Dy/Yr)  
#2 at grade school entry or later \_\_\_\_/\_\_\_\_ (Mo/Yr)
2. Positive Immune Titer (attach report) \_\_\_\_/\_\_\_\_ (Mo/Yr)
3. Check here if born before 1/1/57 – vaccine not required

**Rubella (German Measles) Immunity** – must have one of the following:

1. 1 dose live vaccine on or after 1st birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ (Mo/Dy/Yr)
2. Positive Immune Titer (attach report) \_\_\_\_/\_\_\_\_ (Mo/Yr)
3. Check here if born before 1/1/57 – vaccine not required

**Mumps Immunity** – must have one of the following:

1. 1 dose live vaccine on or after 1st birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ (Mo/Dy/Yr)
2. Date of physician diagnosed disease \_\_\_\_/\_\_\_\_ (Mo/Yr)
3. Positive Immune Titer (attach report) \_\_\_\_/\_\_\_\_ (Mo/Yr)
4. Check here if born before 1/1/57-vaccine not required

**Tetanus/Diphtheria Immunity** - Booster dose of TD given within last 10 years  
(within last 5 years for Wilderness or Off-Campus programs) \_\_\_\_/\_\_\_\_ (Mo/Yr)

## REQUIRED

**Meningococcal Meningitis:** Meningococcal Vaccine groups A, C, Y,  
W-135 \_\_\_\_/\_\_\_\_ (Mo/Yr)

**Tuberculosis** – skin test is required for all, including those |  
who have received a BCG inoculation longer than two (2) years ago.  
(BCG not a requirement)

**PPD (Mantoux)** must have **within past 6 months**

(tine or monovac not acceptable)

PPD Result: Negative \_\_\_\_/\_\_\_\_ (Mo/Yr)

Positive \_\_\_\_/\_\_\_\_ (Mo/Yr)

MM Induration (horizontal diam) \_\_\_\_\_

Chest x-ray required if greater than 10 mm induration

x-ray result: Normal \_\_\_\_/\_\_\_\_ (Mo/Yr)

Abnormal \_\_\_\_/\_\_\_\_ (Mo/Yr)

(attach copy report and record of any treatment)

Received BCG in past: No \_\_\_\_ Yes \_\_\_\_

## RECOMMENDED

Hepatitis B: Completion of at least 2 of 3 in the series

#1 \_\_\_\_/\_\_\_\_ (Mo/Yr) #2 \_\_\_\_/\_\_\_\_ (Mo/Yr) #3 \_\_\_\_/\_\_\_\_ (Mo/Yr)

Hepatitis A

#1 \_\_\_\_/\_\_\_\_ (Mo/Yr) #2 \_\_\_\_/\_\_\_\_ (Mo/Yr)

## OTHER

Polio: Completed primary series of polio immunization Yes \_\_\_\_ No \_\_\_\_  
Date of Booster \_\_\_\_/\_\_\_\_ (Mo/Yr) Vaccine Type \_\_\_\_\_

Varicella (Chickenpox): Diagnosis of disease Yes \_\_\_\_ No \_\_\_\_ Vaccinated \_\_\_\_/\_\_\_\_ (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 \_\_\_\_\_

## 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 \_\_\_\_\_

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:**

	<b>Normal</b>	<b>Abnormal</b>
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\*.**

<b>Limited</b>	<b>Unlimited</b>	<b>Explain limitations</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

**Insurance Information**

Insurance through \_\_\_\_\_ Name of Company \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_  
Policy Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Is your student covered by a prescription card?  Yes  No  
**Please make sure your student arrives on campus with the card.**  
**The student is responsible for filing all insurance claims.**

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