Health History Record

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

Date________________

Class________________

CONFIDENTIAL

Must be completed and returned before July 15

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 ( )__________________
Relationship__________________

Name__________________ Home phone ( )__________________ Bus. Phone ( )__________________
Relationship__________________

Personal Physician__________________________________ Phone ( )__________________
Name and Address

HEALTH INSURANCE INFORMATION

Submit a copy of both sides of your insurance card with this Health History Record and answer the following:

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?

Condition	Yes	No
Alcoholism or chemical dependency	☐	☐
Anemia or other blood disease	☐	☐
Asthma	☐	☐
Bone or joint disease	☐	☐
Cancer	☐	☐
Convulsions/Seizures	☐	☐
Diabetes	☐	☐
Drug or alcohol overdose	☐	☐
Ear/nose/throat disease	☐	☐
Eating disorder	☐	☐
Eye disease	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
Hepatitis	☐	☐
Kidney disease	☐	☐
Major trauma, multiple injuries	☐	☐
Migraine headaches	☐	☐
Meningitis	☐	☐
Mononucleosis	☐	☐
Psychiatric treatment	☐	☐
Psychological problems	☐	☐
Psychological counseling	☐	☐
Pneumonia	☐	☐
Rheumatic fever	☐	☐
Skin disease	☐	☐
Stomach trouble, intestinal disease, or ulcer	☐	☐
Suicide attempt	☐	☐
Tonsillitis	☐	☐
Have you ever had a transfusion?	☐	☐
Hospitalization	☐	☐
Other serious illness?	☐	☐
Other medical problems?	☐	☐
Other disabilities?	☐	☐

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 any dietary restrictions? Please explain. ☐ Yes ☐ No

FAMILY HISTORY

	Age	If Deceased, Age and Year of Death	Cause of Death
Father	________	____________	______________
Mother	________	____________	______________
Siblings	________	____________	______________
	________	____________	______________
	________	____________	______________
	________	____________	______________
	________	____________	______________

Have any of your biological relatives ever had any of the following?

	Yes	No	Relationship
Cancer	☐	☐	______________
Chemical Dependency (including Alcoholism)	☐	☐	______________
Diabetes	☐	☐	______________
Epilepsy-Convulsions	☐	☐	______________
Heart Disease	☐	☐	______________
Kidney Disease	☐	☐	______________
Mental Illness	☐	☐	______________

IMMUNIZATION RECORDS

***Submit an up-to-date copy of your immunization records with this Health History Record.**

Centre College requires the following:

- **Tetanus within the last 10 years**
- **Two Measles, Mumps, and Rubella (MMR) vaccines or proof of immunity**

The American College Health Association recommends the following immunizations: routine childhood vaccinations including either a history of chickenpox or Varicella vaccine, Polio, Meningitis, Hepatitis A, Hepatitis B, HPV, and Tetanus with Pertussis. As recommended by the Advisory Committee for Immunization Practices, all first year students living in residence halls should have received a meningitis vaccine on or after their 16th birthday.

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

Today's Date_______________________________

Name____ **Date of Birth**_______________________________________

Country of Birth (if not U.S.)_____________________________________ **Year of U.S. arrival**__________________________

TUBERCULOSIS (TB) SCREENING FORM

1. Have you ever had a positive TB skin test? ☐ Yes ☐ No

   If Yes, please complete the following:
   - Date of positive test ______/______/______
   - Result __________mm induration
   - Did you take treatment for TB? ☐ Yes ☐ No
     Year of treatment ______ Duration of treatment __________
     Location of treatment ____________________
     Name of TB medication ____________________
   - Please attach proof of a clear chest x-ray performed within the last 3 months, done in the U.S. or stamped at a U.S. Quarantine Station.

2. Have you ever received BCG (TB vaccine given in high risk countries)? ☐ Yes ☐ No

3. Have you lived in a country other than the U.S. for 3 months or more and have been in the U.S. for 5 or fewer years? List country_________________________________ ☐ Yes ☐ No

4. Have you been in close contact with a person known or suspected to have TB disease? ☐ Yes ☐ No

5. Do you or anyone living in your household have a history of injecting illicit drugs or using crack cocaine? ☐ Yes ☐ No

6. Have you worked or lived in a potentially high risk setting such as a homeless shelter, correctional facility, nursing home, or other long term care institution for the elderly, mentally ill, and persons with HIV/AIDS? ☐ Yes ☐ No

7. Have you been diagnosed with a chronic condition that may impair your immune system? (i.e. HIV, Cancer, Silicosis, Leukemia, Lymphoma, Gastrectomy/intestinal bypass, Crohn's, Rheumatoid Arthritis, Diabetes Mellitus, Low body weight (10% or more below ideal), or any condition requiring prolonged corticosteroid therapy/immunosuppressive therapy) ☐ Yes ☐ No

8. Do you currently have any of the following symptoms?
   Cough—longer than 3 weeks in duration ☐ Yes ☐ No
   Fever—unexplained, persistent fever greater than 3 weeks ☐ Yes ☐ No
   Night Sweats—persistent sweating that leaves sheets wet ☐ Yes ☐ No
   Coughing up blood—any blood streaked sputum ☐ Yes ☐ No
   Shortness of breath/chest pain—presently experiencing ☐ Yes ☐ No

If you answered "Yes" to any of the questions 2-8 and have never had a positive TB skin test, you must provide proof of a Tuberculosis skin test (usually a PPD) performed in the U.S. within the last 6 months.

If you will not arrive in the U.S. until the start of the Fall term, answered "Yes" to any of the questions 2-8 and have never had a positive TB skin test, you will need to have a TB skin test done prior to the start of classes.

This test can be done at Parsons Student Health Center, a doctor's office, or at the local health department.

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

Has this student been advised of recommended immunizations? ☐ Yes ☐ No
Please see Immunization Records section of this form.

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?

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:

I grant permission to the Centre College physicians and medical staff to provide routine and acute medical care through Parsons Student Health Center.

I understand that my treatment records will be confidential and that there may be times when confidential information is shared with appropriate Centre College employees as deemed necessary by the staff at Parsons. (i.e. notifying Academic Dean if missing several classes due to illness)

Parsons Student Health Center staff may access/obtain diagnostic reports from another medical facility as it pertains to care given at Parsons when it improves efficiency or continuity of care.

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

I understand that I am financially responsible for any and all medical expenses incurred.

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

I understand that I may amend, change, or cancel this agreement at any time by written notice to Parsons Student Health Center at Centre College.

Student:____ **Date:**____________________

Parent/Guardian:____ **Date:**____________________
(if student is under 18)

Please be sure to read and sign the above authorization