Medical History and Health Form

Part I: Personal

Name ____
(Last Name) (First Name)

Date of Birth _____/_____/_____ Sex: Male ___ Female ___ Age: _____
M D Y

Personal/Family Physician: ________________________Phone # (____)___________

Address: ____

Person to be Notified in Case of Emergency: _________________________________

Relationship: _____________Phone # (____)___________ (____)_____________

Medical Insurance Company _____________________Policy # __________________

Local Ontario Area Doctor ______________________ Phone # __________________

Local Ontario Area Emergency Medical Center _______________________________

(contact your insurance company for the Local Ontario Area information)

***** Send a copy of your insurance card *****

Part II: Medical History

(Attach an additional sheet of paper if necessary)

1. Have you ever had (or currently have) any of the following conditions? If yes, please check next to the condition and explain the situation (including the date) below.

___Asthma ___Ulcers ___Hearing Problems
___Cancer ___Migraines ___Diabetes/Hypogycemia
___Eating Disorders ___Mental Illness ___Epilepsy/Convulsions
___Food Allergies ___Kidney Disease ___Thyroid Disease
___Heart Problems ___HIV Positive ___Other

Please explain any conditions marked above:___________________________________
____
____
____
____

2. What medical conditions have required care in the past five years, if any? __________
____

3. What medications are you taking regularly, if any? ____________________________

4. What allergies do you have, if any? _______________________________________

5. Have you ever been hospitalized? (if yes, list date and reason) __________________
____

6. Have you ever undergone mental health/emotional counseling? __________________
____

7. Is there any other injuries, diseases, medical conditions, or disabilities that you feel we should be aware? ____
____

This information will be kept confidential and used only to ensure the health/safety of the student or the college community.

Student Signature ____ Date _______

Parent/Guardian Signature* _______________________________________ Date _______
(*Required if student is under 18 years of age)

Part III – To be signed by your doctor or health care provider.

Immunization Record*

Hepatitis B Vaccine

Dose #1 _____/_____ (M Y) Dose #2 _____/_____ (M Y) Dose #3 _____/_____ (M Y)

MMR (Measles, Mumps, Rubella) Vaccine

Dose #1 _____/_____ (M Y) Dose #2 _____/_____ (M Y)

Tetanus-Diphtheria Vaccine

Dose #1 _____/_____ (M Y) Dose #2 _____/_____ (M Y) Dose #3 _____/_____ (M Y)

Td booster (within the last ten years) _____/_____ (M Y)

Varicella Vaccine or History of Chickenpox

a. History of Disease _____Yes _____No

b. Vaccine (if no history of disease)

Dose #1 _____/_____ (M Y) Dose #2 (if applicable) _____/_____ (M Y)

Doctor or Health Care Provider

Name______________________________ Address_____________________________

Signature___________________________ Phone(____)_________________________

* If, due to medical reasons or personal beliefs, you decide not to get these immunizations, you must sign an immunization waiver form. Contact the dean of student life for this form.

Return the completed form to the ***Office of Student Life***.