



Medical History
CONFIDENTIAL

RETURN ALL COMPLETED HEALTH FORMS TO DEAN OF STUDENTS' OFFICE IN ROOM 209
If you fail to supply the proper information, your registration may be held, and you may be withdrawn from classes.

<p>Please check all that apply:</p> <p><input type="checkbox"/> New Student</p> <p><input type="checkbox"/> Returning Student</p> <p><input type="checkbox"/> Transfer Student</p> <p><input type="checkbox"/> Athlete</p> <p><input type="checkbox"/> International Student</p> <p><input type="checkbox"/> Nursing or Radiologic Technology Student</p>	<p><input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>Date of Birth: _____</p> <p>Social Security # _____ - _____ - _____</p>
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Name (Please print clearly): _____ Date: _____
Street Address: _____ City, State, Zip _____
Home Phone: _____ Cell Phone: _____

Mother's Name: _____	Father's Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____

Required Immunizations — Medical providers, Please document all immunizations here

Vaccines	Dates Given	Requirements
Tdap or Td	Tdap ___ Td ___ #1 ___/___/___	1 Tdap/Td booster within last 10 years
MMR	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Dates: ___/___/___ ___/___/___ ___/___/___ Measles Mumps Rubella	2 doses or positive titers Minimum of 4 weeks between doses
Meningococcal	1 st year in campus based housing? No ___ Yes ___ (needed) #1 ___/___/___	One dose for first year students living in campus based housing
Varicella	1. History of disease: Yes ___ No ___ (if no proceed to #2) 2. Immunization: #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	2 doses of varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date: ___/___/___	3 doses or positive titer Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 (3 rd dose must be 16 weeks from first dose)
FOR NURSING AND RADIOLOGIC SCIENCE STUDENTS ONLY		

Vaccines	Dates Given	Requirements
Tuberculin (2 step PPD)	#1 ___/___/___ Result: _____ #2 ___/___/___ Result: _____	2 nd PPD within 1 mo. of the 1 st



Student's Name: _____ Date of Birth: _____

INSURANCE/HEALTH CARE PROVIDER INFORMATION

Health/Medical Insurance Company: _____ Policy #: _____ - _____

Address: _____

Subscriber's Name: _____ Subscriber's Phone #: _____

Subscriber's Address: _____

Subscriber's Signature: _____ Subscriber's Date of Birth: _____

Primary Care Physician's Name: _____ Physician Phone #: _____

Must insurance company be contacted prior to treatment? Yes No Contact Number: _____

Non-Emergencies Only

RELEASE OF MEDICAL RECORD INFORMATION AND AUTHORIZATION FOR TREATMENT IN AN EMERGENCY

In case of an emergency where I am unable to provide medical information, I give permission for an authorized agent of Southern Vermont College to release a copy of this medical history form to the treating facility/providers. In the event that I am unable to give consent, I hereby authorize permission for a qualified physician to examine, diagnose, and prescribe or perform treatment that is deemed necessary for the above-named individual.

Signature of Student (parent/guardian if under 18 years of age): _____ Date: _____

If parent/guardian is unavailable, person to contact in the event of an emergency:

Name: _____ Relationship: _____ Phone: _____

Address: _____

INFORMATION RELEASE

FOR NURSING AND RADIOLOGIC SCIENCE STUDENTS:

Please sign below to have your health information released by Southern Vermont College Health Services to the Southern Vermont College Nursing or Radiologic Technology Departments and any organization that require this information affiliation:

Name (Please Print): _____

Signature: _____ Date: _____



Student's Name: _____ Date of Birth: _____

STUDENT HEALTH RECORD

TO BE COMPLETED BY STUDENT (please check appropriate box for each):

	HAVE YOU EVER HAD?		DO YOU NOW HAVE?			HAVE YOU EVERY HAD?		DO YOU NOW HAVE?	
	YES	NO	YES	NO		YES	NO	YES	NO
Asthma	[]	[]	[]	[]	Restricted physical activity	[]	[]	[]	[]
Diabetes	[]	[]	[]	[]	Anxiety / Panic Attacks	[]	[]	[]	[]
Seizures	[]	[]	[]	[]	Hearing or vision problem	[]	[]	[]	[]
Neck/Back problem	[]	[]	[]	[]	Bone or joint trouble	[]	[]	[]	[]
Jaundice/hepatitis	[]	[]	[]	[]	Anorexia or bulimia	[]	[]	[]	[]
Immune disorder	[]	[]	[]	[]	Depression	[]	[]	[]	[]
Thyroid problems	[]	[]	[]	[]	Drug or alcohol problem	[]	[]	[]	[]
Mononucleosis	[]	[]	[]	[]	Tobacco dependency	[]	[]	[]	[]
Anemia	[]	[]	[]	[]	Frequent headaches	[]	[]	[]	[]
ADD /ADHD	[]	[]	[]	[]	Physical impairment	[]	[]	[]	[]
Heart disease	[]	[]	[]	[]	High blood pressure	[]	[]	[]	[]
Hernia	[]	[]	[]	[]	Kidney disease	[]	[]	[]	[]
Cancer	[]	[]	[]	[]	Chicken pox	[]	[]	[]	[]

LIST ALLERGIES: _____

LIST CURRENT MEDICATIONS: _____

LIST SURGERIES & DATES: _____

LIST ANY OTHER PERTINENT MEDICAL INFORMATION: _____

STATEMENT OF PHYSICAL EXAMINATION

Practitioner: Please address the student's general state of health, conditions currently under treatment that may affect his/her academic status or quality of care, and any limitations on physical activity.

Signature of Health Care Provider: _____ Date: _____

Health Care Provider's Telephone Number: _____