



# Health and Medical History Record

The college requires a medical history and updated immunizations. You will not be allowed to register until this completed medical record has been received by the College Health Center. ***The information on the Health Form is confidential and will be used only as an aid in providing necessary health care while you are a student.***

Adrian College, Health Center, 110 S. Madison Street, Adrian, Michigan 49221 ● 517-265-5161 ext. 4214 ● Fax: 517-264-3112

\_\_\_\_\_  
Last Name, First, Middle

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Home Street Address

\_\_\_\_\_  
Sex, Age, Birthdate

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Home Telephone

### Person to contact in case of an Emergency:

\_\_\_\_\_  
Last Name, First, Middle

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Business Telephone

\_\_\_\_\_  
Business Address

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
City, State, Zip

### Family Physican

\_\_\_\_\_  
Last Name, First

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone

### Family History:

	Age	State of Health	Occupation	Age of Death	Cause of Death	Blood Relatives	Yes	No	Relationship
Father						Tuberculosis			
						Diabetes			
Mother						Kidney Disease			
						Heart Disease			
Brother(s)						Arthritis			
						Stomach Disease			
						Asthma/Hay Fever			
						Epilepsy Convulsions			
Sister(s)						Allergies			
						Anemia/Blood Problems			
						Cancer			
						High Blood Pressure			
						Nervous/Mental Problems			

**Personal Health History:**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Other Allergies \_\_\_\_\_

Current Medications: list all medications taken regularly and those you take without a prescription \_\_\_\_\_

**Please answer the following questions below. Please check the appropriate box and comments that indicate yes and provide approximate dates.**

	Yes	No	Approx. Date
Tuberculosis			
Asthma or other breathing problems			
Bronchitis/pneumonia			
Frequent colds, sore throats, sinus or ear problems			
Vision Correction			
Contact lenses? Type:			
Dental Problems			
<input type="checkbox"/> Chicken pox <input type="checkbox"/> Measles <input type="checkbox"/> Rubella <input type="checkbox"/> Mumps			
Mononucleosis			
Thyroid disease			
Diabetes			
Hypoglycemia			
Heart trouble/history of murmur/rheumatic fever			
High Blood Pressure			
Cancer or tumor			
Breast disease			
Anemia/bleeding problems			
Immune disease			
Epilepsy/seizures			
Blackout/loss of consciousness			
Headaches: Chronic/Migraine			
ADD/ADHD			
Speech or hearing problems			

	Yes	No	Approx. Date
Intestinal disease/abdominal pain			
Stomach/ulcer problems			
Hernia			
Hemorrhoids			
Liver or gallbladder problems			
Kidney or urinary problems/infections			
Back pain/joint problems			
Muscular/nerve problems			
Physical limitations			
Treatment or Experienced:			
anxiety			
depression			
alcohol/substance abuse			
eating disorder			
emotional disorder			
psychiatric disorder			
Hospitalizations/surgeries:			
Female: Pap smear                      Results:			
Contraception:                      Type used:			
Irregular menstruation/dysmenorrhea			
Vaginitis			
Males: Testicular problems			

I have personally supplied the above information and attest that it is true and complete to the best of my knowledge.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# Immunization Record

All information must be in English. **To be completed and signed by your health care provider or submit verified copy of High School immunization record.** These immunizations are required. Registration may be delayed if immunizations requirements are not met.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First M.I.

## REQUIRED IMMUNIZATIONS

- A. Tetanus-Diphtheria**  
1. Tetanus-Diphtheria booster must be within the last 10 years \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.
- B. M.M.R. (Measles, Mumps, Rubella) Two doses required.**  
1. Dose 1 given at 12-15 months after birth or later \_\_\_\_\_ #1 \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.  
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose \_\_\_\_\_ #2 \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.  
OR Has report of positive rubeola titer. Specify date and attach lab report \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.
- C. Polio**  
1. Completed primary series of polio immunization: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last booster \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.
- D. Hepatitis B**  
1. Dose #1 \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr. Mo. Yr. Mo. Yr.
- E. Varicella (Chicken Pox) History of Disease:** Yes \_\_\_\_\_ No \_\_\_\_\_  
OR Varicella immunization: Dose #1 \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr. Mo. Yr.  
OR Varicella antibody \_\_\_\_\_ / \_\_\_\_\_  Reactive  Non-Reactive  
Mo. Yr.

## RECOMMENDED IMMUNIZATIONS

- F. Hepatitis A:** Dose #1 \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr. Mo. Yr.
- G. Meningococcal (One dose)** \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr.
- H. Combined Hepatitis A & B Vaccine** Dose #1 \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_  
Mo. Yr. Mo. Yr. Mo. Yr.
- I. Tuberculin (TB) Skin Test:** To assess your need for a TB skin test, please answer the following questions.  
1. Do you have signs or symptoms of active tuberculosis? (i.e., weight loss, undiagnosed cough, night sweats) \_\_\_\_\_ Yes \_\_\_\_\_ No  
2. Are you a member of a high-risk group or have you traveled to any countries with high rates of TB? \_\_\_\_\_ Yes \_\_\_\_\_ No  
(see back for countries with high rates)

If the answer to either of these questions is yes, you are required to have a **CURRENT** (within one year of entering Adrian College or upon your return to the United States) TB skin test. If you have a positive test, you must submit a chest x-ray report.

If you answered "no" to both questions, you may proceed to K.

**J. Tuberculosis** (PPD required regardless of prior BCG inoculation.)

1. PPD (Mantoux) within the past 12 months (tine or monovac not acceptable)  
Result: Neg \_\_\_\_\_ Pos \_\_\_\_\_ . . . . . /  
Mo. Yr.
2. If PPD is positive, chest X-ray required. X-ray result: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal . . . . . /  
Mo. Yr.

**K.** Please list any other vaccines received and dates (e.g. Lyme's Disease, HIB) \_\_\_\_\_

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**Health Care Provider or High School Designee** (Signature required for this form or attach a verified copy of your immunization record.)

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Name (print) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

\_\_\_\_\_

Health care provider signature \_\_\_\_\_

High School designee signature \_\_\_\_\_

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**Countires with High Rates of Tuberculosis (TB)\***

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Afghanistan	Colombia	India	Moldova, Rep.	Senegal
Angola	Comoros	Indonesia	Mongolia	Sierra Leone
Armenia	Congo	Iran	Morocco	Solomon Islands
Azerbaijan	Congo, DR	Iraq	Mozambique	Somalia
Bahamas	Cote d'Ivoire	Kazakhstan	Myanmar	South Africa
Bahrain	Croatia	Kenya	Namibia	Sri Lanka
Bangladesh	Djibouti	Kiribati	Nepal	Sudan
Belarus	Dominican Rep.	Korea, DPR	New Caledonia	Suriname
Benin	Ecuador	Korea, Rep.	Nicaragua	Swaziland
Bhutan	El Salvador	Kyrgyzstan	Niger	Syrian Arab Rep.
Bolivia	Equatorial Guinea	Lao PDR	Nigeria	Tajikistan
Bosnia & Herzegovina	Eritrea	Latvia	Niue	Tanzania, UR
Botswana	Estonia	Lesotho	Northern Mariana Islands	Thailand
Brazil	Ethiopia	Liberia	Pakistan	Togo
Brunei Darussalam	Gabon	Lithuania	Palau	Tokelau
Burkina Faso	Gambia	Macedonia, TFYR	Panama	Turkmenistan
Burundi	Georgia	Madagascar	Papua New Guinea	Uganda
Cambodia	Ghana	Malawi	Paraguay	Ukraine
Cameroon	Guam	Malaysia	Peru	Uzbekistan
Cape Verde	Guatemala	Maldives	Philippines	Vanuatu
Central African Rep.	Guinea	Mali	Portugal	Vietnam
Chad	Guinea-Bissau	Marshall Islands	Romania	Yemen
China	Guyana	Mauritania	Russian Federation	Zambia
China, Hong Kong SAR	Haiti	Mauritius	Rwanda	Zimbabwe
China, Macao SAR	Honduras	Micronesia	Sao Tome & Principe	

\* World Health Organizaton. Global tuberculosis control. WHO report 2002.



## Statement and Consent

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- I authorize Adrian College Health Center staff to examine and treat me as within their professional guidelines and judgment for the illness/injury I am presenting. Referrals or consultations with other health professionals will be made as necessary in order to meet my health care needs.
- I authorize Adrian College Health Center staff, administrator, Office of Student Affairs staff, and Campus Safety Officers to arrange for ambulance or other emergency transportation and emergency room treatment in case of serious injury, illness or other conditions.
- I authorize Adrian College Health Center to release any information contained in my medical record to an insurance agency or carrier for the purpose of obtaining payment for my treatment and care, and any health care facility, physician or other provider for the purpose of providing continuing care and treatment.
- I authorize any doctor, hospital or other medical agency to release confidentially to the Adrian College Health Center any information they may have concerning my medical condition and care given during their professional contact with me.
- I understand that the information I have provided on this form and information the Adrian College Health Center compiles in the course of examination, treatment or other services provided to me as a student will be treated confidential. Information in my Health Center records will be released to others only:
  - A. with my written consent
  - B. in case of an emergency, to obtain necessary care and treatment; and
  - C. as required by law.
- If enrolled in the student health insurance, I hereby authorize that the Adrian College insurance agent, First Agency of Kalamazoo, Michigan, pay the medical vendors directly for any covered bills incurred in the course of my treatment.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Printed Name \_\_\_\_\_

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### For all applicants under 18 years of age

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Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Printed Name \_\_\_\_\_