FORM E

AFFIX LABEL HERE *or complete the following:*

LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS

HIGH SCHOOL/COLLEGE PHONE

BIRTH DATE MAJOR CLASS YEAR

FIRST-YEAR / TRANSFER SMC ID#

Health History Form

DUE: 07/01/11

Instructions and Information - Important Please Read!

- **Information provided is confidential.**
- **Please include a copy of your health insurance card with this form and bring a copy with you to college.**
- **Return completed form to Student Health Services, Box 259, Saint Michael's College, Colchester, Vermont 05439 by July 1, 2011.**
- **You MUST purchase Saint Michael's Student Health Insurance or you MUST waive the coverage (if you are covered under another plan). See page 34 for information and instructions.**

Health History

EMERGENCY CONTACT INFORMATION (may be a parent/spouse/guardian)

Name(s):_____ Relationship:_____

Telephone numbers in case of an emergency: Cell Phone(s):_____

Home Phone(s):_____ Business Phone(s):_____

LIST ALL MEDICATIONS CURRENTLY BEING TAKEN:

Medication	Dosage	Frequency	Reason

IF YOU ARE UNDER 18 YEARS OF AGE UPON ENTRANCE TO COLLEGE, PARENTAL/GUARDIAN CONSENT IS NECESSARY.

I, _____ (parent or guardian), pursuant to the authority vested in me, do hereby authorize Student Health Services of Saint Michael's College to exercise for me and on my behalf, all rights and duties with reference to appropriate emergency medical, psychiatric and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by any hospital and/or health care provider which they may deem necessary for:

_____ _____ _____

(Print student's full name) (Parent/guardian's signature) (Date)

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM.

CONTINUED...

DO YOU HAVE TRUE ALLERGIES TO ANY OF THE FOLLOWING?

Medication: ☐ YES ☐ NO LIST: _____

Food: ☐ YES ☐ NO LIST: _____

Environment: ☐ YES ☐ NO LIST: _____

Other: ☐ YES ☐ NO LIST: _____

☐ Check here if you would like to schedule allergy injections while at college.

	YES	NO	DATE(S)	PLEASE EXPLAIN
Have you ever had surgery?				
Have you ever been hospitalized overnight?				

DO YOU OR ANY BLOOD RELATIVES (parents, siblings, grandparents or children only) HAVE A HISTORY OF ANY OF THE FOLLOWING HEALTH ISSUES?

_____ Check here if your family health history is unknown and continue to complete your personal health history below.

YOU		YOU	RELATIVE	
_____	ADD or ADHD	_____	_____	Alcohol or drug abuse
_____	Anemia	_____	_____	Anxiety
_____	Asthma	_____	_____	Bleeding or clotting disorder
_____	Concussion	_____	_____	Cancer
_____	Eating Disorder	_____	_____	Depression
_____	Eye Disease or Blindness	_____	_____	Diabetes
_____	Hearing loss	_____	_____	Elevated cholesterol or lipids
_____	Hepatitis	_____	_____	Frequent or severe headaches
_____	Liver conditions (chronic)	_____	_____	Gastrointestinal disorder
_____	HIV positive or AIDS	_____	_____	Heart disease
_____	Kidney infection or disease	_____	_____	High blood pressure
_____	Mental health issue	_____	_____	Rheumation arthritis
_____	Mononucleosis	_____	_____	Sickle cell trait or disease
_____	Organ absence or abnormality	_____	_____	Stroke
_____	Pelvic infection	_____	_____	Seizure disorder
_____	Pneumonia	_____	_____	Suicide or attempted
_____	Sexually transmitted infection	_____	_____	Thalessemia
_____	Sexual assualt or abuse	_____	_____	Thyroid disorder
_____	Tobacco use (cigarette or chew)	_____	_____	Tuberculosis
_____	Urinary tract infection	_____	_____	Other

Please explain checked boxes, as needed _____

_____

_____