



**SAINT MICHAEL'S COLLEGE**

# HEALTH HISTORY FORM

**AFFIX LABEL HERE** or complete the following:

Last Name	First Name	Middle Initial
Address		
High School / College		Phone
Birth date	Major	Class Year
(circle): First-Year / Transfer    Male / Female		SMC ID#

## 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 by July 1, 2008.

## 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.**

**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	_____	_____ Rheumatoid arthritis
_____ Mononucleosis	_____	_____ Sickle cell trait or disease
_____ Organ absence or abnormality	_____	_____ Stroke
_____ Pelvic infection	_____	_____ Seizure disorder
_____ Pneumonia	_____	_____ Suicide or attempted
_____ Sexually transmitted infection	_____	_____ Thalassemia
_____ Sexual assault or abuse	_____	_____ Thyroid disorder
_____ Tobacco use (cigarette or chew)	_____	_____ Tuberculosis
_____ Urinary tract infection	_____	_____ Other

Please explain checked boxes, as needed \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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# IMMUNIZATION RECORD

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(circle): First-Year / Transfer		Male / Female	SMC ID#

*This form should be completed by your health care provider.*

Vaccines	Dates Given	Requirements
Tdap or Td (Tetanus)	Tdap ___ Td___ #1___/___/___	1 Tdap/Td booster within last 10 years (Tdap preferred)
MMR	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Dates: ___/___/___ ___/___/___ ___/___/___ Measles Mumps Rubella	2 doses or positive titers  Minimum of 4 weeks between doses 1st dose given after 1st birthday
Bacterial Meningitis	#1 ___/___/___	One dose for students living in campus based housing
Varicella (Chicken Pox)	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 if age or older (12 weeks for under age 13)
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 (3rd dose must be 16 weeks from first dose)

**Health Care Provider Information:**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Please return this form as soon as possible, but no later than July 1, 2008, to:**

**Saint Michael's College**  
**Student Health Services**  
 One Winooski Park, Box 259  
 Colchester, Vermont 05439  
 Ph: 802-654-2234 • Fax: 802-654-2699