



SAINT MICHAEL'S COLLEGE

Student Health Services

This health form must be returned prior to arrival at Saint Michael's College

PLEASE TYPE OR PRINT

Name _____ Date of Birth _____ / _____ / _____
month day year

Home Address _____
Street

_____ City State ZIP

Gender: Male Female Citizenship: USA Other _____

■ Do you have any handicap or disability? Yes No
If yes, explain:

■ Do you have or are you under treatment for any medical problems, including heart disease? Yes No
If yes, explain:

■ Do you have any allergies? Yes No
If yes, explain:

■ Have you ever had surgery? Yes No
If yes, explain:

■ Have you ever been hospitalized? Yes No
If yes, explain:

■ List all medications currently being taken with dosage, frequency and condition:

MEDICINE	DOSAGE	FREQUENCY	CONDITION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunization Record

FILL IN DATES OR CHECK APPROPRIATE BOXES.

Vermont law requires adequate immunization against measles. All students born after 1956 must supply: **a)** dates of two MMR (measles, mumps, rubella) or measles *or* **b)** proof of immunity against measles (a blood test result).

Measles (Rubeola) - *Must have 2nd MMR injection since 1980*

DATES

Completed primary series of MMR immunizations

____ / ____

Most recent booster

____ / ____

~~—or—~~

Proof of immunity attached.

____ / ____

If possible please attach a copy of any other immunization received especially tetanus, hepatitis, and tuberculosis.

Consent of parent/guardian for regular medical treatment an emergencies if you are less than 18 years old:

I _____, pursuant to the authority vested in me as parent/guardian on _____
parent/guardian date

do hereby authorize the Health Service of Saint Michael's College to exercise for me and on my behalf, all rights and duties with reference to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by any hospital, staff surgeon, physician, or radiologist which they may deem necessary for the care of

_____ print student's full name

_____ parent/guardian's signature



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Student Health Services
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