Bergeron Wellness Center

Healthy History

SAINT MICHAEL'S COLLEGE FOUNDED 1904

DEADLINE
As soon as possible

RETURN BY MAIL, EMAIL, OR FAX

Saint Michael's College
Attn: Student Health Services
One Winooski Park, Box 259
Colchester, VT 05439
Email: healthservices@smcvt.edu
Fax: +1.802.654.2699

Instructions and Information

- Information provided is confidential.
- Please include a copy of your health insurance card with this form and bring a copy with you to college if you have waived the Saint Michael's College insurance plan with the online waiver form.

Please Complete the Following:

_____
Last (Family) Name First Name Middle Initial

_____ _____ _____
Birth Date SMC ID# Class Year

Gender (please circle):

Male Female Transgender Non-Binary Prefer Not to Disclose

_____ _____
Preferred Name Preferred Pronoun

Alternate Email: _____

Cell Phone: _____

Please note: All students are billed roughly $2,000 for the mandatory Saint Michael's College health insurance each year unless they complete the online health insurance waiver form. A live link to the form will be sent to students through their SMC email in July

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

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM; SIGNATURE REQUIRED >

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: _____

SURGERY/HOSPITALIZATION

Have you ever had surgery? ❑ YES ❑ NO DATE(S): _____
PLEASE EXPLAIN:_____

Have you ever been hospitalized overnight? ❑ YES ❑ NO DATE(S): _____
PLEASE EXPLAIN:_____

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 health history below.

YOU	YOU	RELATIVE
❑ ADD or ADHD	❑	❑ Alcohol or drug abuse
❑ Anemia	❑	❑ Anxiety
❑ Asthma	❑	❑ Bleeding or clotting disorder
❑ Concussion	❑	❑ Cancer
❑ COVID 19 - IF YES, DATE: _____	❑	❑ Depression
❑ Eating disorder	❑	❑ Diabetes
❑ Eye disease or blindness	❑	❑ Elevated cholesterol or lipids
❑ Hearing loss	❑	❑ Frequent or severe headaches
❑ Hepatitis	❑	❑ Gastrointestinal disorder
❑ Liver conditions (chronic)	❑	❑ Heart disease
❑ High blood pressure	❑	❑ HIV positive or AIDS
❑ Kidney infection or disease	❑	❑ Rheumatoid arthritis
❑ Mental health issue	❑	❑ Sickle cell trait or disease
❑ Mononucleosis	❑	❑ Stroke
❑ Organ absence or abnormality	❑	❑ Seizure disorder
❑ Pelvic infection	❑	❑ Suicide or attempted
❑ Pneumonia	❑	❑ Thalassemia
❑ Sexually transmitted infection	❑	❑ Thyroid disorder
❑ Sexual assault or abuse	❑	❑ Tuberculosis
❑ Tobacco use (cigarette or chew)	❑	❑ Other
❑ Urinary tract infection	❑	❑ Other

Please explain checked boxes, as needed

_____
_____
_____

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