



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#	

DUE: 07/01/11

Health History Form

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)

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 _____
