HIRAM COLLEGE

INTIMATE LEARNING. GLOBAL REACH.

Hiram College Julia Church Health Center
6780 Hinsdale St. PO Box 67
Hiram, OH 44234
Ph: 330-569-5418 Fx: 330-569-5398

This health record is a requirement for admission to Hiram College and must be on file in the Health Center. Complete history and physical exam and return to the above address.

The information requested on this form is divided into two parts. Part one is to completed by the student/parent and Part two should be completed by your primary health care provider.

Please print all information:

Name Date of Birth Student Cell Phone

Address City State Zip Code Country

Parents name Home Phone Business or Cell Phone

Emergency Number Name Relationship

Personal History: If you have had any of the following please check

Allergies		Appendicitis		Asthma	
Anemia		Bipolar Disease		Blood Diseases	
Arthritis		Broken Bones		Bronchitis	
Cancer		Chicken Pox		Concussion	
Convulsions		Diabetes		Drug Overdose	
Epilepsy		Eating Disorder		Ear Infections	
Heart Disease		Heart Murmur		Headaches (severe)	
Hepatitis		High Blood Pressure		Kidney Disease	
Mononucleosis		Psychological Problems		Psychological Counseling	
Pneumonia		Rheumatic Fever		Hernia	
Skin Disease		Suicide Attempt		Thyroid Disease	
Stomach or Intestinal Problems		Any Chronic Disease		Unconsciousness	
Other Serious Illness or Injuries					

Explanations of any above checked answers____
____
____

List any surgeries or hospitalizations ____
____
____

Please list all medications (including dosage) that you are currently taking_________________________________

____

Allergies:

Medication ___________________________________ Food ____
Enviromental ___________________________________ Bee stings ______________________________________

Consent and Release

Permission is hereby voluntarily granted to the Director of Health Services, the College Physician(s), nurses and employees of Julia Church Health Center to do all such things as may be necessary to diagnose, treat and care for the needs of the student named below. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as the result of the treatment or examination in the Julia Church Health Center.

I certify that I understand the contents of this consent form, and that my signature represents a free voluntary act of consent there to on behalf of the student named below. I further certify that I expect any specific information regarding any service from the Julia Church Health Center will not be released without the express written consent of the student unless disclosure is mandated by law or in the professional judgment of the Director of Health Services or the College Physician(s) is necessary to protect the physical safety of the student or the community at large.

I hereby authorize any health care facility or health care provider to furnish to the Director of Health Services or the College Physician(s) medical records and information pertaining to the medical history, mental or physical condition, services rendered, or treatment of the patient named below. This authorization shall remain in effect until revoked in writing. A photocopy of this authorization shall be deemed as valid as the original.

In case of illness or accident deemed serious by the Director of Health Services or the College Physician(s), I authorize said persons to notify the parent or guardian named on my medical history form, and the Dean of Students Office if I am unable to do so. I hereby authorize the College Physician(s) or Director of Health Services operating in collaboration with the College Physician to hospitalize me in case of emergency.

The Privacy Act Practices Document has been provided for me and I have read the document and understand my privacy rights as a patient in the Hiram College Julia Church Health Center.

____ ____________________

Signature of Student Date

____ ____________________

Signature of parent/guardian if student is less than 18 years of age Date

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Date of Birth