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

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

Please print all information:

Name	Date of Birth		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

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

Explanations of any above checked answers_____
_____
_____

List any other surgeries or hospitalizations

_____
_____

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

Medication _____ dose _____
prescribing doctor_____ for condition _____
Medication _____ dose _____
prescribing doctor_____ for condition _____
Medication _____ dose _____
prescribing doctor_____ for condition _____
Medication _____ dose _____
prescribing doctor_____ for condition _____

Patient Name_____ **Date of Birth** _____

Allergies:

Medication_____Food_____

Enviromental _____ Bee stings _____

Please complete required immunization fields with appropriate dates or attach a copy of

complete immunization records.

Required Immunization Records:

A. M.M.R. (MEASLES, MUMPS, RUBELLA) (Two doses required)

1. Dose 1 given at age 12-15 months or later . . . . . #1 ___/___/___
M D Y

2. Dose 2 given at 4-6 yrs. and at least 28 days after first dose . . . . . #2 ___/___/___
M D Y

B. POLIO

1. Completed primary series of polio immunization: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
M D Y M D Y M D Y

2. Type of vaccine: Live (OPV) _____ Inactivated (IPV) _____

C. TETANUS-DIPHTHERIA-PERTUSSIS

Primary series with DTaP, DTP, DT, or Td, and booster with TD or Tdap in the last ten years. Health sciences students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate. Refer to ACIP for details.

1. Primary series of four doses with DTaP, DTP, DT, or Td:
#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
M D Y M D Y M D Y M D Y

2. Booster:
Tdap (preferred). ___/___/___ **OR** Td ___/___/___
M D Y M D Y

D. Meningitis and Hepatitis B Vaccine Status (as required by Ohio Revised code, 3701.133,13)

Meningitis received ___ yes ___ no Hepatitis B received ___yes ___no

Recommended but not required

D. MENINGOCOCCAL

Date ___/___/___
M D Y

E. VARICELLA

1. History of Disease Yes _____ No _____ Vaccinated #1___/___/___ #2 ___/___/___
M D Y M D Y

F. HEPATITIS A

1. Immunization (hepatitis A)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___
M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)
a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___
M D Y M D Y M D Y

G. HEPATITIS B

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___
M D Y M D Y M D Y

H. GARDASIL

a. Dose #1 ___/___/__ b. Dose #2 __/___/__ c. Dose #3 ___/___/__
M D Y M D Y M D Y

Patient Name_____ **Date of Birth** _____

I. TUBERCULOSIS SCREENING [1]

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2. If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin test, chest x-ray and sputum evaluation as indicated.

2. History of BCG? Yes _____ No _____ Proceed to 3.

3. Is the student a member of a high-risk group? Yes _____ No _____
If No, stop. If yes, place tuberculin skin test. A history of BCG vaccination should not preclude testing of a member of a high-risk group.[2]

4. Tuberculin Skin Test:
Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")
Interpretation (based on mm of induration as well as risk factors): positive____ negative____

5. Chest x-ray (required if tuberculin skin test is positive) result: normal____ abnormal____
Date of chest x-ray: ____/____/____
M D Y

***For ease of care, please also attach a copy of medical and prescription cards.**

1 The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

2 Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence.

Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndomes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

Patient Name _____ **Date of Birth**_____

Consent and Release

Permission is hereby voluntarily granted to the Director of Health Services, the College Physician(s), nurses, counselors 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 named student. 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. 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), College Counselor or Director of Student Health Services to refer me to the appropriate facility for evaluation in case of medical or mental health emergency.

Student athletes: The Hiram College Health Center and the Hiram College Athletics work in conjunction to achieve the best patient outcomes for our student athletes. I hereby authorize release of medical information that is relevant my participation in athletics to the Hiram College athletic trainers, coaching and/or administrative staff, Hiram College team physician and/or associates.

The Privacy Act Practices Document has been provided for me, I am aware it can be found at http://www.hiram.edu/images/pdfs/health-services/privacy-act-practices.pdf. 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