

**Information about yourself**

The College requires students to have a medical history form on file at the Student Health Center. This information is confidential and will not influence your standing at Champlain College.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Male  Female  Social Security #: \_\_\_\_\_Permanent home address: \_\_\_\_\_  
Street City/Town State Zip

Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Birth date: \_\_\_\_\_

Health insurance: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

*Address:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_*Home phone:* \_\_\_\_\_ *Work phone:* \_\_\_\_\_List any medications you take regularly: \_\_\_\_\_  
\_\_\_\_\_

List any medications that have caused an abnormal reaction:

*Medication:* \_\_\_\_\_ *Reaction:* \_\_\_\_\_*Medication:* \_\_\_\_\_ *Reaction:* \_\_\_\_\_List any recent hospitalization or surgery you have had, including dates and reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_List any chronic illness you have, such as asthma, diabetes, psychiatric condition, learning disabilities, ADD, ADHD, alcohol and/or drug abuse:  
\_\_\_\_\_  
\_\_\_\_\_**To be completed and signed by parent or legal guardian**

Notice to parents: Before any treatment may be administered to a student who is a **MINOR**, area hospitals require that permission be received. This consent form must be signed by the parents so that emergency procedures may be carried out promptly and no unnecessary delays occur with less urgent procedures. However, no surgery will be performed, except in extreme emergency, without the parents being contacted and fully informed.

In an emergency, call:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I give my permission for such medical procedures as may be deemed necessary for my son/daughter.

Parent/Guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_



**Personal Health History**

YES	NO		COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back Problem	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain or Abnormality	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	_____
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	_____
<input type="checkbox"/>	<input type="checkbox"/>	Consumption of Alcohol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression/ Counseling	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug Usage	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections (frequent)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fracture (list which bones)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraines (frequent)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur or Problem	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure/High Cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Joint or Limb Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pap Smear Abnormality/Pelvic Infection	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Fainting	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problem (Acne, Eczema)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Bowel Problem	_____
<input type="checkbox"/>	<input type="checkbox"/>	Testes/Scrotum Problem	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	_____
<input type="checkbox"/>	<input type="checkbox"/>	Underweight/Overweight	_____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	_____
<input type="checkbox"/>	<input type="checkbox"/>	Use of Tobacco Products	_____

**Family Health History**

YES	NO		COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	_____

Student's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**To be completed and signed by a PHYSICIAN**

An accurate immunization history is required of all new students regardless of age. This document must be signed by a health care professional and returned in order for the student to register for classes. All dates must include month/day/year.

Vermont state law requires that all full-time and part-time students born after 1956 who are enrolled in post-secondary schools are required to have all of the following immunizations. Proof of these immunizations must be kept on file in the Health Services office.

*Student: Complete top portion and have the remaining portion completed by your health care provider.*

Name: \_\_\_\_\_  
Last First M.I. Suffix

Address: \_\_\_\_\_  
Street City/Town State Zip

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Enrollment: \_\_\_\_\_ / \_\_\_\_\_  
Month Year

VACCINES	DATES GIVEN	REQUIREMENTS
<b>Tdap or Td</b>	Tdap ____ Td ____ #1 _____ / _____ / _____	1 Tdap/Td booster within last 10 years
<b>MMR</b>	#1 _____ / _____ / _____ #2 _____ / _____ / _____ OR Positive Titer Dates: ____ / ____ / ____    ____ / ____ / ____    ____ / ____ / ____ <small>Measles Mumps Rubella</small>	2 doses or positive titers Minimum of 4 weeks between doses First dose given after 1st birthday
<b>Meningococcal</b>	First year in campus-based housing? No ____ Yes ____ (needed) #1 _____ / _____ / _____ <i>Must have in order to live in Campus Housing.</i>	One dose for first year students living in campus-based housing
<b>Varicella</b>	1. History of disease? Yes ____ No ____ (if no, proceed to #2) <small>MUST sign Vt. Dept. of Health "Documentation of Varicella" form.</small> 2. Immunizations: #1 _____ / _____ / _____ #2 _____ / _____ / _____ OR Positive Titer Date: _____ / _____ / _____	2 doses of varicella vaccine <b>or</b> history of disease <b>or</b> positive titer Minimum of 4 weeks between doses if age 13 or older (12 weeks for under age 13)
<b>Hepatitis B</b>	#1 _____ / _____ / _____ #2 _____ / _____ / _____ #3 _____ / _____ / _____ OR Positive Titer Date: _____ / _____ / _____	3 doses <b>or</b> positive titer Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 (3rd dose must be 16 weeks from first dose)

**Tuberculosis Test/PPD within one year of admission (Mandatory for Radiography majors):**

Skin test date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Result: \_\_\_\_\_  
If positive, follow-up X-ray is REQUIRED.

Physician's name (printed): \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City/Town State Zip

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed and signed by a PHYSICIAN**

An entrance physical exam is required for Education and Radiography majors. You must have a physician complete this form.

Student's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Please indicate below, by a check in the column on left, any positive findings on the physical examination or any handicapping disability. Describe fully in section on right.

- Nutrition
- Skin
- Eyes
- Teeth
- Tonsils/Adenoids
- Lymph Glands
- Heart
- Lungs
- Abdomen
- Genito-Urinary
- Orthopedic

Description of positive findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Injury history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Brief medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications/allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*I have examined the above patient and find him/her physically and mentally fit for all college activities, including allied health training.*

Physician's name (printed): \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

*Street*

*City/Town*

*State*

*Zip*