

MEDICAL AUTHORIZATION AND HEALTH HISTORY FORM
HARRISON HEALTH CENTER
ST. JOHN'S COLLEGE
P.O. Box 2800
Annapolis, Maryland 21404

To the Student:

YOU HAVE BEEN ACCEPTED TO ST. JOHN'S COLLEGE. Information you provide will not be used to influence your situation at the College. Information provided on this form is confidential and will not be released to anyone without the student's written consent. Please sign the Emergency Medical Authorization and General Consent, which are necessary to enable us to provide your health care, or, if you are under 18, please have your parents sign. PLEASE RETURN THIS FORM DIRECTLY TO THE HEALTH CENTER STAFF IN THE HARRISON HEALTH CENTER IN THE ENVELOPE PROVIDED.

Emergency Medical Authorization

In case of emergency, if I (we) cannot be reached, I (we) give my (our) consent for the Dean, Assistant Dean, College Nurse, or College Physician of St. John's College, Annapolis, Maryland, and Santa Fe, New Mexico, to authorize the health care provider in charge of the case, and the hospital to which the case of

Name of Student

is taken to administer any treatment, including blood transfusions, and to administer such anesthetics, and to perform such operations as may be deemed medically necessary in the diagnosis and treatment of the above named person.

Student's date of birth

Student signature if age 18 or over

Witness

Parent or Guardian if student under 18

Date

Consent to communication of medical information

I authorize the Health Center clinicians to communicate information about my condition to my insurance company as necessary to obtain reimbursement for my expenses, to specialists as necessary to diagnose and treat my medical conditions, to diagnostic laboratories as needed to perform testing and to other Health Center clinicians as necessary to care for me and to monitor and improve the quality of care.

Student signature if age 18 or over/Parent if student is under 18 years Date

Contact information

In case of emergency, notify (parent, guardian or spouse):

Name _____ Relationship _____
Home address _____ City, State _____ Zip code _____
Home phone () _____ Business phone () _____ Cell phone() _____

Student's primary care provider:

Name _____ Address: _____ Phone: () _____

Student's health insurance:

Company: _____ Address: _____ Phone: () _____

Is the primary care provider's authorization required for all diagnostic testing and/or referral to specialists?

yes no

STUDENT'S CELL PHONE # IF APPLICABLE _____

Family History

| | Age | Health status | Occupation | If deceased, age and cause of death |
|----------|-----|---------------|------------|-------------------------------------|
| Father | | | | |
| Mother | | | | |
| Sisters | | | | |
| Brothers | | | | |

State relationship of blood relative--**parents, grandparents, and siblings**--who have had:

| | | |
|-------------------|---------------------|--------------------------|
| Alcoholism | Epilepsy | Psychiatric illness |
| Bleeding disorder | Heart disease | Stroke |
| Cancer | High blood pressure | Tuberculosis |
| Diabetes | Infectious disease | Other hereditary disease |

Inactive medical problems

Give the approximate age at which you had any of the following:

| | | |
|----------------------------|----------------|-------------------------------|
| Allergies, seasonal | Head injury | Migraine |
| Anorexia nervosa | Hearing loss | Mononucleosis |
| Asthma | Heart disease | Obsessive-compulsive disorder |
| Attention deficit disorder | Heart murmur | Rheumatic fever |
| Bipolar disorder | Hepatitis | Schizophrenia |
| Bleeding disorder | Herpes | Seizures |
| Bulimia | Joint injury | Suicide attempt |
| Chicken pox | Kidney disease | Thyroid disease |
| Depression | Liver disease | Tuberculosis |
| Diabetes | Malaria | Ulcer |
| Fainting | Meningitis | Other medical illness |

Hospitalizations for injury, illness, surgery or diagnostic testing:

1. _____ Age _____ 2. _____ Age _____

Current Problems: Please rank by circling the severity: 0 is for absent, 1,2,3 for increasing severity/frequency

| | | |
|------------------------------|---|---------------------------|
| Acne 0 1 2 3 | Domestic violence 0 1 2 3 | Sexual abuse 0 1 2 3 |
| Alcohol abuse 0 1 2 3 | Fainting 0 1 2 3 | Suicidal thoughts 0 1 2 3 |
| Allergies 0 1 2 3 | Food restrictions, self-imposed 0 1 2 3 | Other: |
| Anxiety 0 1 2 3 | Headaches 0 1 2 3 | |
| Attention deficit 0 1 2 3 | Indigestion 0 1 2 3 | |
| Depression 0 1 2 3 | Insomnia 0 1 2 3 | |
| Discord with parents 0 1 2 3 | Menstrual problems 0 1 2 3 | |

Medication information:

Prescription medications: _____
 Over the counter medications: _____

Allergies to medications:

Allergic to _____ (name of medication) Reaction this medication elicits: _____

Health Risks:

The following section asks about risky behaviors that college-age individuals sometimes adopt. The top health risks for college students are:

1. Accidents, often related to alcohol consumption
2. Upper respiratory illness, often related to smoking
3. Infectious diseases, often related to sexuality
4. Unwanted pregnancy

Please answer the following questions, and come to the Health Center after classes have begun to discuss your health risks. If you do not wish to be candid on this form, please come to the Health Center after classes have begun to discuss these matters in person.

Smoking:

Non-smokers are safest.

Do you smoke? yes no If yes, how many packs per day? _____

Alcohol and other mind-altering substances:

Abstinence is safest.

Do you drink alcohol? no less than one drink/week 1-4 drinks/week more than 1 drink/day

Do you use street drugs? yes no If yes, what drug? _____ How often? _____

Automobile safety:

The safest practice is to always use seatbelts, never to drive after drinking alcohol, and to decline to ride with an individual who has been drinking alcohol.

Do you use seatbelts while riding in automobiles? yes no

Do you drive after drinking alcohol? yes no Do you ride with people who have been drinking? yes no

Interpersonal conflicts:

It is safest to remove oneself from proximity with individuals who are physically violent, and to seek counseling if you have trouble curbing violent impulses.

Have you been physically violent with yourself or others? yes no

Sexuality:

Abstinence is safest.

If sexually active:

Are you having safe sex? yes no Are you using contraception? yes no

Health maintenance

If you need information or counseling on any of these subjects, please ask your Primary Care Provider or come to the health center after school begins.

All students:

Have you been to the dentist in the past year? yes no

Are your immunizations up to date and adequate for your lifestyle? yes no

Recommended immunizations completed by age 18:

Tetanus booster every 10 years

Measles/mumps/rubella, 2 doses

Hepatitis B, 3 doses, usually initiated at age 11

Meningitis, 1 dose or 2 if > 5 years since 1st dose

Are you exercising for ½ hour at least 3 times a week? yes no

Are you eating at least 5 servings of fruits or vegetables a day? yes no

Do you have a source of calcium in your daily diet? yes no

Do you have a method of dealing with stress? yes no What is the method? _____

Female students:

Have you had a Pap smear in the past year? yes no Was it normal? yes no

Do you know how to do a breast self-exam? yes no Do you do it monthly? yes no

Male students:

Do you know how to do a testicular self-exam? yes no Do you do it monthly? yes no

To be completed by Student's Primary Care Provider:

Student's Name _____

Date of Birth _____

IMMUNIZATION RECORD

Required: to be completed and signed by your health care provider or attach copies of records

Tetanus booster within 10 years. Date ___/___/___ (check ___Td or ___Tdap)

Measles vaccine (MMR). Two doses **required**.

Dose 1 given at age 12-15 months or later. Date ___/___/___

Dose 2 given at age 4-6 years or later. Date ___/___/___

Meningitis (MCV4) required Date ___/___/___

If meningitis vaccine administered > 5 years-booster dose required

Date ___/___/___

Hepatitis B (recommended 3 doses). Dates ___/___/___, ___/___/___, ___/___/___

Polio (optional). Date ___/___/___

ALLERGIES TO MEDICATIONS: _____

Physical examination:

BP _____ Pulse _____ Height _____ Weight _____

Corrected vision: Right 20/___ Left 20/___

| Normal | System examined: | Abnormalities: |
|--------|--------------------------|----------------|
| | Head, ears, nose, throat | |
| | Eyes | |
| | Cardiovascular | |
| | Pulmonary | |
| | Gastrointestinal | |
| | Genitourinary | |
| | Musculoskeletal | |
| | Skin | |
| | Neurologic | |

PRIMARY CARE PROVIDER'S SIGNATURE _____ **DATE** _____

Print name: _____

Address _____

City, State _____ Zip Code _____

Telephone number () _____

Fax number _____

Email address _____