HARRISON HEALTH CENTER
ST. JOHN'S COLLEGE
60 College Avenue
Annapolis, Maryland 21401

Medical Authorization And Health History Form

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 at the above address by August 1.

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 Practitioner, 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	PRINT NAME	DATE
ADDRESS	CITY, STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS