Belmont Abbey College Health Services - Student Medical History

Name: Last_____First_____Middle_____ Date_____

Date of Birth Gender: Class: College athlete? Team_____

Address_____ City_____State_____Zip_____ Country_____

Personal Email_____Student cell phone #_____ Nickname_____

PARENT/GUARDIAN INFORMATION

Name_____Relationship_____Cell phone #_____

Name_____Relationship_____Cell phone #_____

Address_____City_____State_____Zip_____

EMERGENCY CONTACT INFORMATION

Name #1_____Relationship_____Phone #_____

Name #2_____Relationship_____Phone #_____

PRIMARY CARE PHYSICIAN

Name_____Phone_____

Address_____City_____State_____Zip_____

INSURANCE INFORMATION (Please carry your insurance card or take a picture of the front and back of your card to have with you at all times)

Name of Insurance company_____

Name of Policyholder_____

Are you purchasing or waiving the school insurance? ◯ Purchasing ◯ Waiving

ALLERGIES/ADVERSE REACTIONS (medications/insect bites/food/latex/environmental) ☐ **None**

Adverse reaction to:	Type of reaction:

MEDICATIONS (Prescription, over the counter, allergy injections, Epi-Pen, birth control, vitamins, herbal) ☐ **None**

Medication:	Taken for:	Dosage:	Frequency:	Date started:	For staff only Date ended

Name: Last_____First_____Middle_____Date_____

MEDICAL HISTORY (Present or past history- check all that apply) ☐ **None**

- ☐ ADHD/ADD
- ☐ Allergies:
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding/Clotting problems
- ☐ Blood Pressure (high or low)
- ☐ Broken Bones _____
- ☐ Cancer_____
- ☐ Cholesterol
- ☐ Covid Date:_____
- ☐ Concussion
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Ear trouble/Hearing Loss
- ☐ Eating Disorder
- ☐ Eye Problems
- ☐ Gallbladder trouble
- ☐ Headaches (recurrent)
- ☐ Heart Disease/problems
- ☐ Heart Murmur
- ☐ Hernia
- ☐ HIV
- ☐ Hypoglycemia (Low blood sugar)
- ☐ Intestinal/Stomach trouble
- ☐ Joint Disease/Injury
- ☐ Kidney Problems/Stones
- ☐ Liver Disease (Hepatitis/Jaundice)
- ☐ Lymph Node enlargement
- ☐ Meningitis
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Neck injury
- ☐ Numbness/tingling of arms/legs
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Anemia/trait
- ☐ Sinus trouble
- ☐ Skin problems:
- ☐ Sleep Problems
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Urinary Tract Infections
- ☐ Other- please explain in space below

Females only:

- ☐ Irregular menstrual cycles
- ☐ Abnormal PAP
- ☐ Pregnancy
- ☐ Significant premenstrual symptoms

Other:

MENTAL/PSYCHOLOGICAL HEALTH ☐ **None**

Have you had severe symptoms and/or treatment for:

☐ Anxiety ☐ Depression ☐ Eating Disorder ☐ Mental or Emotional Disorder ☐ Suicidal thoughts ☐ Suicidal attempts

Please explain:

HOSPITALIZATIONS ☐ **None**

Reason	Year	Comments

SURGERIES ☐ **None**

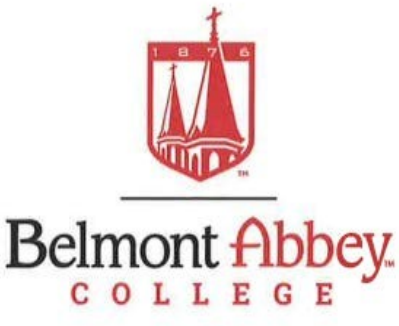
Reason	Year	Comments

FAMILY HISTORY ☐ **None**

Have parents, siblings or grandparents had any of the following? If adopted and history unknown, check here ☐

	Relationship		Relationship
☐ Diabetes	_____	☐ Sickle cell anemia	_____
☐ High blood pressure	_____	☐ Thyroid	_____
☐ Stroke	_____	☐ Liver disease	_____
☐ High Cholesterol	_____	☐ Depression/mental illness	_____
☐ Heart attack before 55	_____	☐ Alcoholism	_____
☐ Cancer (type)_____	_____	☐ Other serious illness_____	_____

Name: Last_____First_____Middle_____Date_____



I understand that the information I supplied is confidential and will not be released to anyone without my verbal consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to give my consent, I hereby give my permission to the Wellness Center to release my medical information to one of my emergency contacts that I have listed on this Student Medical History form, a physician, hospital and/or other medical professionals involved in providing me with emergency treatment and/or medical care.

I understand that my personal health information is only to be accessed by our Wellness Center staff as part of fulfilling their job duties and providing or assisting in the provision of health care.

I understand that when I seek health care from the Belmont Abbey College Wellness Center, they have my permission to collect, use and share my personal health information among the health care providers and administrative staff at the Wellness Center who provide or assist in providing health care to me.

During the Covid19 pandemic, I understand that if I contract covid, the Wellness Center team will need to disclose this information to a select few outside the Wellness Center that are on a "need to know" basis in order to provide services to me while I am in isolation and also for the staff to be able to take measures to help prevent the spread of covid to others in the campus community.

I give my implied consent for the Wellness Center staff to share my personal health information on a "need-to-know" basis with other healthcare providers outside the wellness Center who are directly involved in my health care.

I also give my implied consent to share personal health information with health insurance providers for billing-related purposes.

Campus Community

The Wellness Center may be contacted by an individual (i.e. parent/family member, friend, faculty or staff member, ResLife, Student Affairs, Campus Security or Campus Ministry who is concerned about your well-being. We will collect information from these individuals and may reach out to you, as appropriate to follow-up on the concerns that have been brought to our attention, and to connect you to supports if needed. We inform the concerned individual that we may reach out to you, but no additional information will be provided unless you grant this consent. We may inform individuals on a 'need to know basis' that you have used our services, but we do not disclose any personal health information about you, unless you grant consent for us to do so or there is believed to be an imminent risk to your safety or the safety of someone else.

I hereby authorize any medical treatment for myself (or for my son/daughter if he or she is under the age of 18) that may be advised or recommended by the nurses, Nurse Practitioner and/or her supervising physician of the Wellness Center. I may refuse care or treatment at any time.

By typing below, I acknowledge that I have read, understand and accept the practices described above.

Student Name_____

Student Signature_____

Signature of Parent or Guarding if student is under age 18_____

Date_____