Due: July 1, 2009

Bates College Health History Form

(Confidential)

Health Center
31 Campus Ave.
Lewiston, ME 04240
Phone: 207-786-6199
Fax: 207-786-8240

Please answer every question and return to the Health Center by ***July 1***. Complete this form before taking the Physician's Evaluation to your Doctor. Submission of this form is required before matriculation can occur.

M ☐ F ☐

Last Name ____ First Name ____ Middle Initial ____

Date of Birth ____ Place of Birth ____ College Class ____ Social Security No. ____

EMERGENCY NOTIFICATION

Please provede the name of your parent/guardian and someone to call if a parent/guardian is not available.

1. Father's Name ____ occupation ____
Street ____ City, State, Zip ____
Telephone: home ____ cell phone ____ email ____

2. Mother's Name ____ occupation ____
Street ____ City, State, Zip ____
Telephone: home ____ cell phone ____ email ____

3. Emergency Contact ____ relationship ____
Street ____ City, State, Zip ____
Telephone: home ____ cell phone ____ email ____

Permission for Emergency Treatment

(To be signed by parent, or guardian, or student if 18 years or older)

On occasion, a surgical emergency may arise when we are unable to contact a parent or consult the patient. Anesthesia cannot be administered to, or any operation performed on, a minor without this consent. In order not to delay any procedure necessary to safeguard the health of a student, we request that the following permission be signed.

I hereby grant permission to the College Physician, if I cannot be reached or communicated with, to hospitalize and provide any treatment necessary for my son, daughter, or ward, or myself (cross out terms not applying), according to professional judgment, if further delay might jeopardize health.

Date ____ Signature ____

Next of kin other than parent or guardian to be notified in case of emergency: Name ____

Address ____ Telephone (   ) ____

SOURCES OF HEALTH CARE

Please list the names, addresses and telephone numbers of physicians, psychologists, or other health care providers you now consult.

Name ____
Field of Practice ____
Address ____
City, State ____
Telephone ____
Fax ____

Name ____
Field of Practice ____
Address ____
City, State ____
Telephone ____
Fax ____

All medical records are confidential.

Health Insurance Info - Please include a copy of the front & back of your insurance card.

Name: ______________________________ Date of birth: ______________
LAST FIRST

PERSONAL HEALTH HISTORY

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Sinustitis				Jaundice or hepatitis				Concussion/head inj.			
Hearing Loss				Kidney or bladder infection				Migraines			
Ear, nose, throat problems				Gallbladder/pancreatic problems				Frequent or severe headaches			
Eye trouble				Kidney stone				Epilepsy, seizures			
Fainting Spells				Missing kidney/paired organ				Paralysis			
Rheumatic Fever				Albumin or blood in urine				Learning disability			
Shortness of breatth				Abnormal pap test				ADD/ADHD			
Congenital heart disease				Fibrocystic breasts				Worry or anxiety			
Mitral valve prolapse				Irregular menstruation				Clinical depression			
Pneumonia				Sexually transmitted infection				Monoucleuiss			
Asthma				Neck or back injury				Cigarette/tobacco use			
Chronic cough				Shoulder injury				Tumor or cancer			
TB/Postitive TB test				Arm injury				Obesity			
Skin disease				Knee injury				Eating disorder			
Hernia				Ankle injury				Malaria			
Irritable bowel syndrome				Other leg injury				Anemia or other Blood Disorders			
Stomach or intestinal problems				Arthritis, rheumatism, or bursitis							
Diabetes				Other orthopedic problems							
Thyroid problems				Heat intolerance							

Comments on any *YES* answers: ______________________________

MEDICAL HISTORY

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medication, antidepressants, etc.

ALLERGIES: List known allergies and type of reaction/Epipen?

Medication allergies: ______________________________

Foods: ______________________________

Environmental: ______________________________

Hospitalization: Have you ever been hospitalized for any surgical, medical or psychiatric illness? ☐ yes ☐ no

If yes, please specify diagnosis and date ______________________________

Have you received counseling or psychiatric care within the last six years? ☐ yes ☐ no

Are you taking meds for depression, anxiety, ADD/ADHD, disturbance of mood, thought or behavior? ☐ yes ☐ no

FAMILY HISTORY

Have parents, siblings, grandparents had any of the following? If adopted and history unkown, check here _____ .

	Yes	No	Relationship		Yes	No	Relationship	Comments
Diabetes				Cancer (type:)				
High Blood Pressure				Sickle cell anemia				
Stroke				Thyroid disease				
High Cholesterol				Depression/mental illness				
Heart attack before 55				Liver disease				
Alcoholism				Other serious illness				

If either parent or sibling is deceased, Please list relationship to you, age at death, and cause of death.

PLEASE USE __THIS FORM__ AND COMPLETE ALL QUESTIONS

Date ____________

BATES COLLEGE PHYSICAL EXAM FORM

To the examining physician: Please review with student's health history form and complete this physical examination form. We ask that you comment on all abnormalities. Examinations by physician parents or siblings will be not be accepted. Please return to: The Health Center, Bates College, Lewiston, Maine 04240 **immediately.** (For Athletic Physicals, check required deadlines)

Last Name: ____________ First: ____________ M.I. ______

Date of Birth: ____________ Class: ____________ Male ☐ Female ☐

Home Phone #:(   ) ____________ Bates/cell #: ____________

Insurance Company Name: ____________

Policy Holder's Name: ____________ Policy: ____________

List all Sports at Bates: ____________

Clinical Evaluation

D.O.B. | Height | Weight | Blood Pressure (sitting) | Pulse

	Normal	Abnormal
1. EENT	☐	☐
2. Thyroid	☐	☐
3. Chest and Lungs (Include Breasts)	☐	☐
4. Heart (history of exercise-induced problems: fainting, irregular rate?	☐	☐
5. Heart Murmur (include details and restrictions)	☐	☐
6. GI (hernia, etc.)	☐	☐
7. Endocrine system	☐	☐
8. Spine	☐	☐
9. Extremities	☐	☐
10. Lymphatics	☐	☐
11. Identifying body marks - scars, skin lesions	☐	☐
12. Neurologic	☐	☐
13. Genito Urinary (males include testicles)	☐	☐

	NO	YES
14. Is this student under treatment for any medical issues?	☐	☐
15. Are there any dietary restrictions?	☐	☐
16. History of eating disorders/concerns?	☐	☐
17. Is this student under treatment for any psychological issues?	☐	☐
18. Any medication or therapy?	☐	☐
19. Are there any restrictions on physical activity?	☐	☐
20. Are there any sports this student is unable to participate in?	☐	☐
21. How long have you know this student?	☐	☐

FOR ALL SPORTS PHYSICALS: Please write on the back of this form pertinent health history including major illnesses, hospitalizations, surgeries, traumatic head injuries, orthopedic injuries, and cardiac problems. For serious injuries or illnesses within the past year, please include any restrictions and a note of clearance to play sports. (First year students playing sports - please use separate sheet if needed.)

____

Signature of physician   Address   Telephone (include area code) / Fax

Release of Information

I ____________ (print name) hereby authorize and request that the Bates College Health Center and Bates College Sports Medicine be permitted to verbally communicate, send, and receive medical information, obtained in the course of treatment for injury or illness which is relevant to my participation in athletic activities, and includes my Complete Physical Exam form required for athletic participation.

Student Signature ____________ Date ____________

First Year Students Only: Please complete **immunization** information on the other side.

Please enclose the certificate of immunization and/or evidence of immunity. Mail by July 1 to:
Bates College health Center
31 Campus Ave.
Lewiston, ME 04240-6085
Fax: 207-786-8240

Required Immunization and Screening

The State of Maine **will not accept** as proof of immunization, a simple listing of immunizations the student received or history of measles, mumps, or rubella (German Measles). **We must have**: A copy of the high school immunization record, or a copy of the original immunization certificate, or a laboratory titer report as proof of immunity.

Measles (Rubeola) Two doses of measles vaccine administered **after,** not on the first birthday. **In many cases a third vaccine will be needed. Please use MMR.**

Mumps Two doses of mumps vaccine, administered **after,** not on, the first birthday.

Rubella Two doses of rubella vaccine, administered **after,** not on, the first birthday.

MMR Vaccine #1 ______________________________
month/date/year **Include proof of immunization**

MMR Vaccine #2 ______________________________
month/date/year MD Signature

Tetanus/Diphtheria Three primary doses of DPT or DT (pediatric) or TD (adult) age appropriately administered constitutes a minimally acceptable number of doses. Additionally, a booster dose of TD must be administered every 10 years following the completion of a basic series.

Tetanus/Diphtheria (if needed) ______________________________
month/date/year MD Signature

Recommended Vaccines: the following vaccinations are strongly recommended but not required. Students needing to complete the Hepatitis B vaccine series may do so a the Health Center at cost.

Hepatitis B Vaccine #1 ____________ #2 ____________ #3 ____________
date / MD Signature date / MD Signature date / MD Signature

Varivax Vaccine (chicken pox) ______________________________
date / MD Signature

Meningococcal vaccine ______________________________
Polysaccharide meningococcal vaccine or Menactra? Please circle date / MD Signature

The American College Health Association recommends that colleges provide information about meningitis and that the meningitis vaccine be made available to first year students living in dormitories. Meningitis information is available on our website at www.bates.edu/admin/offices/health/meningitis.html

SPORTS MEDICINE RELEASE - PLEASE SIGN

I ______________________________ Hereby authorize and request that the Bates College Health Center
Print Name

and Bates College Sports Medicine be permitted to verbally communicate, send, and/or receive medical information, obtained in the course of treatment for injury or illness which is relevant to my participation in athletic activities, and includes my complete Physical Exam form required for participation in varsity sports.

Student Signature ______________________________ Date ____________