

MEDICAL RECORDS

Last name	First name	Middle initial	Date of birth	M	F
				Sex (Circle)	
Home address	City	State	ZIP	Home phone number	
Student health insurance company	Policy Holder	Policy number (please attach copy of insurance card)			
Class Status (Circle): Freshman Sophomore Junior Senior Graduate Postbac Premed					
Social Security number					

IN CASE OF EMERGENCY, NOTIFY:

Name	Relationship				
Home address	City	State	ZIP	Home phone number	
Work address	City	State	Zip	Work phone number	

HISTORY

Acne	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Hypoglycemia (low blood sugar)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
ADD/ADHD	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Infectious mononucleosis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
If "current" please visit: http://www.goucher.edu/x43494.xml				Irritable Bowel Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
AIDS, ARC, or positive HIV	<input type="checkbox"/> Current		<input type="checkbox"/> Never	Kidney infections/stones	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Alcohol problem	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Knee injury	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Allergies	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Learning disability	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Anemia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Migraine headache/Vascular H/A	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Anxiety disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Obesity (more than 20 lbs. overweight)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Asthma	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Ovarian cyst	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Back problems	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Pelvic infection	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Bladder infection (cystitis)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Peptic ulcer (gastric or duodenal)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Bleeding trait/sickle cell	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Phlebitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Bronchitis—chronic	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Pneumonia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Cancer (location)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Rheumatic fever	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Chlamydia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Rheumatoid arthritis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Colitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Sinus problem—chronic	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Concussion	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Suicide attempt	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Condyloma (genital warts—HPV)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Syphilis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Depression	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Thyroid problem	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Diabetes	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Tension headaches	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Drug dependency	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Tuberculosis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Eating disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Vaginitis (recurrent)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Eczema	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Varicella (chickenpox)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Emotional/mental illness	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Other problem not listed (specify)	_____		
Epilepsy/seizures	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Eye problem (specify)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Fainting	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Injuries, surgeries, and hospitalizations	_____		
Gallbladder problems	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Gonorrhoea	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Gout	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Hay fever	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Hearing loss	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Dietary needs	_____		
Heart problems (specify)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Rheumatic heart disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Heart murmur	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Hepatitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
Herpes (genital)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		
High blood pressure	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never		_____		

Have you traveled outside the U.S. in the past year? Yes No

CURRENT HEALTH INFORMATION

Goucher College Student Health and Counseling

Last name First name Middle initial

1021 Dulaney Valley Road • Baltimore, Maryland 21204-2794
410-337-6050 • www.goucher.edu/health
410-337-6051 (fax)

Mental Health History:

- Have you ever received psychiatric care/counseling? Yes No Currently
- Have you ever been hospitalized for psychiatric care? Yes No
- Have you ever been treated for an eating disorder? Yes No
- Have you ever been treated for alcohol or drug dependency? Yes No
- If "yes" to any of the above, please indicate you have read the following: Yes No

Understanding Campus and Community Counseling Services available at <http://www.goucher.edu/x43496.xml>

List all current prescription medications:

Medication name	Prescribing provider	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any known allergies? Yes No

If "yes," please list:

Have you received allergy shots? Yes No Currently If "yes" or "current" please visit: <http://www.goucher.edu/x32166.xml>

Family History	Age	Status of Health	Occupation	If deceased, age and cause of death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Are you adopted? Yes No

You are invited to discuss your answers or any other health issues with the Student Health Services professional staff.

The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within Student Health Services.

Applicant's Signature

Date

PHYSICAL EXAM

To be completed by physician, physician's assistant, or nurse practitioner no more than six months prior to admission.

Goucher College Student Health and Counseling

1021 Dulaney Valley Road • Baltimore, Maryland 21204-2794
410-337-6050 • www.goucher.edu/health
410-337-6051 (fax)

Last name First name Middle initial

BP _____ Heart Rate _____ Height (in.) _____ Weight (lbs.) _____

Examination Findings (Describe fully. Use additional sheets if necessary.)

	NL	ABN	Findings (describe)		NL	ABN	Findings (describe)
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose/sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuro	<input type="checkbox"/>	<input type="checkbox"/>	_____

General comments _____

Recommendations for physical activity (PE, intramural) Unlimited Limited

Explain _____

Is the patient now under treatment for any medical or emotional condition? Yes No

Explain _____

Do you have any recommendations regarding the care of this student? Yes No

Explain _____

Practitioner's signature _____ Phone number _____

Print last name _____ Date _____

Address _____ City _____ State _____ ZIP _____

Return to Goucher College Student Health Services, 1021 Dulaney Valley Road, Baltimore, MD 21204-2794 / Phone: 410-337-6050 / Fax: 410-337-6051

AUTHORIZATION FOR TREATMENT OF MINORS

If the student has not yet reached her or his 18th birthday before the beginning of the academic year for which the student is registered, the following authorization by a parent or legal guardian is required.

I hereby grant permission to Goucher College to proceed with any needed medical, mental health, or minor surgical treatment, X-ray examinations, and immunizations for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named student may be given.

Signature Date

Printed name Relationship to student

Home phone number Work phone number

STUDENT IMMUNIZATION RECORD

(Form must be completed and returned before registration)

Goucher College Student Health and Counseling

1021 Dulaney Valley Road • Baltimore, Maryland 21204-2794
410-337-6050 • www.goucher.edu/health
410-337-6051 (fax)

To be completed by the student:

Last name First name Middle initial

Date of Birth Social Security number **M F**
Sex (Circle)

MANDATORY IMMUNIZATIONS FOR GOUCHER COLLEGE REGISTRATION

To be completed and signed by a health care provider. (Dates must include month, day, and year)

M.M.R. (Measles, Mumps, Rubella)

Option 1

Dose 1—Immunized at 1 year or after

____ / ____ / ____

Dose 2—At least 4 weeks after dose 1

____ / ____ / ____

OR M.M.R. Titer (Measles, Mumps, Rubella)

Option 2

Lab report of titer _____

Copy of report must be attached

Tetanus-Diphtheria

(Td Booster within last 10 years)

TD ____ / ____ / ____

OR

Tdap ____ / ____ / ____

Meningococcal Vaccine Information

For individuals 18 years or older:

I am 18 years of age or older. I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is rare but life-threatening illness. I understand that Maryland law requires an individual enrolled in an institution of higher education in Maryland who resides on campus in student housing shall receive vaccination against meningococcal disease unless the individual signs a waiver.

Meningococcal Waiver

I choose to waive the meningococcal vaccine.

Signature of student (parent if student is not 18)

Date ____ / ____ / ____

OR Meningococcal Vaccine

MCV (Menactra/Menveo)

____ / ____ / ____

OR

MPSV (Menomune)

____ / ____ / ____

If vaccine has not been received, meningococcal waiver must be signed by student/parent

Tuberculin Test

Students must have had a PPD or TB blood test within the last two years, unless there is a history of a positive PPD or TB blood test. Please note: A PPD or TB blood test is required regardless of BCG history.

History of NEGATIVE TB test

Date of test ____ / ____ / ____

Test used _____

Date read ____ / ____ / ____

Interpretation _____

History of POSITIVE TB test

Date of test ____ / ____ / ____

Test used _____

CXR results _____

Follow up ____ / ____ / ____

OTHER IMMUNIZATIONS

Hepatitis B (recommended)

Dose 1 ____ / ____ / ____

Dose 2 ____ / ____ / ____

Dose 3 ____ / ____ / ____

Hepatitis A (recommended)

Dose 1 ____ / ____ / ____

Dose 2 ____ / ____ / ____

Hepatitis A/B

Dose 1 ____ / ____ / ____

Dose 2 ____ / ____ / ____

Dose 3 ____ / ____ / ____

Other

Varicella

History of Disease (Year) _____

OR

Dose 1 ____ / ____ / ____

Dose 2 ____ / ____ / ____

HPV (Quadrivalent Human Papillomavirus Vaccine)

Dose 1 ____ / ____ / ____

Dose 2 ____ / ____ / ____

Dose 3 ____ / ____ / ____

Health Care Provider (include title):

Practitioner's signature

Print last name

Date

Address

City

State

Zip

Phone number