GOUCHER | college

Student Health Services

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

MEDICAL RECORDS

Last name | First name | Middle initial | Date of birth

Home address | City | State | ZIP | phone number

Chosen Name | Gender identity: _____ | Pronouns: _____

Class status (circle): **First year** **Sophomore** **Junior** **Senior** **Graduate** **Postbac Premed**

IN CASE OF EMERGENCY, NOTIFY:

Name | Relationship

Home address | City | State | ZIP | Home/Cell phone number

Work address | City | State | ZIP | Work phone number

MEDICAL HISTORY

Acne	☐ Current	☐ Past	☐ Never
ADD/ADHD	☐ Current	☐ Past	☐ Never
If "current" please visit: www.goucher.edu/healthforms			
AIDS, ARC, or positive HIV	☐ Current		☐ Never
Allergies	☐ Current	☐ Past	☐ Never
Anemia	☐ Current	☐ Past	☐ Never
Asthma	☐ Current	☐ Past	☐ Never
Back problems	☐ Current	☐ Past	☐ Never
Bleeding trait/sickle cell	☐ Current	☐ Past	☐ Never
Cancer (location)	☐ Current	☐ Past	☐ Never
_____			
Celiac disease	☐ Current	☐ Past	☐ Never
Concussion/head injury	☐ Current	☐ Past	☐ Never
Diabetes	☐ Current	☐ Past	☐ Never
Epilepsy/seizures	☐ Current	☐ Past	☐ Never
Eye problem (specify)	☐ Current	☐ Past	☐ Never
_____			
Fainting/dizziness	☐ Current	☐ Past	☐ Never
Gallbladder problems	☐ Current	☐ Past	☐ Never
Hearing loss/deafness	☐ Current	☐ Past	☐ Never

Heart problems (specify)	☐ Current	☐ Past	☐ Never
_____			
Heart murmur	☐ Current	☐ Past	☐ Never
Hepatitis	☐ Current	☐ Past	☐ Never
High blood pressure	☐ Current	☐ Past	☐ Never
Hypoglycemia (low blood sugar)	☐ Current	☐ Past	☐ Never
Infectious mononucleosis	☐ Current	☐ Past	☐ Never
Irritable bowel disease	☐ Current	☐ Past	☐ Never
Kidney infections/stones	☐ Current	☐ Past	☐ Never
Migraine headache/vascular H/A	☐ Current	☐ Past	☐ Never
Obesity (more than 20 lbs. overweight)	☐ Current	☐ Past	☐ Never
Peptic ulcer (gastric or duodenal)	☐ Current	☐ Past	☐ Never
Pneumonia	☐ Current	☐ Past	☐ Never
Rheumatic fever	☐ Current	☐ Past	☐ Never
Rheumatoid arthritis	☐ Current	☐ Past	☐ Never
Skin disorder (specify)	☐ Current	☐ Past	☐ Never
_____			
Thyroid problem	☐ Current	☐ Past	☐ Never
Tuberculosis	☐ Current	☐ Past	☐ Never
Varicella (chickenpox)	☐ Current	☐ Past	☐ Never

Other problems not listed (specify)

_____

Injuries, surgeries, and hospitalizations

_____

Dietary needs

_____

Smoking status ☐ Yes ☐ No # per day _____

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

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CURRENT HEALTH INFORMATION

Last name First name Middle initial

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 anxiety/depression?	☐ Yes	☐ No	☐ Currently
Have you ever been treated for an eating disorder?	☐ Yes	☐ No	
Have you ever been treated for alcohol or drug dependency?	☐ Yes	☐ No	
Have you ever attempted suicide?	☐ Yes	☐ No	☐ Dates _____
If "yes" to any of the above, please indicate you have read the following:	☐ Yes	☐ No	

Understanding Campus and Community Counseling Services available at
https://www.goucher.edu/experience/staying-healthy/counseling-services/documents/counselingservices.pdf

List all current prescription medications:

Medication name	Prescribing provider	Phone #

Do you have any known allergies? (Including medications or food) ☐ Yes ☐ No

If "yes," please list:

Do you have an epi pen? ☐ Yes ☐ No

Family History

	Age	Status of health	Occupation	If deceased, age and cause of death
Parents:				
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 a physician, physician's assistant, or nurse practitioner no more than twelve months prior to admission.

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Last name _____ First name _____ Middle initial _____

BP_____ **Heart Rate**_____ **Height** (in.)_____ **Weight** (lbs.)_____

M F INTERSEX
Biological sex (circle)

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

	NL	ABN	Findings (describe)		NL	ABN	Findings (describe)
General appearance	☐	☐		Neck	☐	☐	
Skin	☐	☐		Chest	☐	☐	
Head	☐	☐		Heart	☐	☐	
Eyes	☐	☐		Abdomen	☐	☐	
Nose/sinus	☐	☐		Extremities	☐	☐	
Mouth	☐	☐		Neuro	☐	☐	

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 _____

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 / www.HealthForms@goucher.edu

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 medical provider to contact me in the most expeditious manner possible. If said provider 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)

To be completed by the student:

Last name First name Middle initial

Date of birth

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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 the meningococcal vaccine. I understand that meningococcal disease is a 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 to 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 _____ /_____ /_____

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

OR

Meningococcal Vaccine

MCV (Menactra/Menveo/Menomune)

Date _____ /_____ /_____

MCV Booster

(if initial dose was give before 16th birthday)

Date _____ /_____ /_____

Menigitis Type B Vaccine

Date _____ /_____ /_____

Date _____ /_____ /_____

TUBERCULIN TEST (MANDATORY)

All students at Goucher are required to study abroad therefore they 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_____

Attach report

Completed Therapy _____/_____/_____

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

Dose 1 _____ /_____ /_____
Dose 2 _____ /_____ /_____
Dose 3 _____ /_____ /_____

Health Care Provider (include title):

Practitoner's signature Print last name Date

Address City State ZIP Phone number

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Student name

Date of birth

HEALTH INSURANCE COMPANY

Name

Policyholder

Policy No. Group No.

Insurance company address City State ZIP

Insurance company phone number

COPY OF INSURANCE CARD MUST BE ATTACHED.

17382-5709 02/17