

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	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Heart problems (specify)	<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	_____			
If "current" please visit: www.goucher.edu/healthforms				Heart murmur	<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	Hepatitis	<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	High blood pressure	<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	Hypoglycemia (low blood sugar)	<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	Infectious mononucleosis	<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	Irritable bowel disease	<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	Kidney infections/stones	<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	Migraine headache/vascular H/A	<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
Celiac disease	<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
Concussion/head injury	<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
Diabetes	<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
Epilepsy/seizures	<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
Eye problem (specify)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Skin disorder (specify)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
_____				_____			
Fainting/dizziness	<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
Gallbladder problems	<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
Hearing loss/deafness	<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

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? _____

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

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 www.goucher.edu/documents/counseling/community12017.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.

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

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	<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 _____

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)

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

To be completed by the student:

Last name First name Middle initial

Date of birth

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

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):

Practitioner's signature

Print last name

Date

Address

City

State

ZIP

Phone number

STUDENT HEALTH INSURANCE

Goucher College Student Health and Counseling

Student name

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

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.