LANDMARK COLLEGE

2019 ELO-STEM Program

Health History & Emergency Contact Information Form

Full Student Name: **Date of Birth:** _____

Emergency contact #1
Full Name _____ relationship:_____
Number to call in case of emergency: _____ ❒Cell Phone ❒Home Phone ❒Work Phone

Emergency contact #2
Full Name _____ relationship:_____
Number to call in case of emergency: _____ ❒Cell Phone ❒Home Phone ❒Work Phone

Emergency contact #3
Full Name _____ relationship:_____
Number to call in case of emergency: _____ ❒Cell Phone ❒Home Phone ❒Work Phone

Parent/Guardian Authorizations

This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all program activities except as noted. I give permission to the college to arrange necessary related transportation for my son or daughter. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the college to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off campus.

Signature of parent /guardian **Printed Name** **Date**

_____ _____ _____

I also understand and agree to abide by any restrictions placed on my participation in program activities.

Signature of student **Date**

_____ _____

Health History

The following information must be completed by the parent/guardian. The intent of this information is to provide health care personnel with medical information in order to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be upon participant's arrival. Provide complete information so that the college can be aware of your needs.

MEDICATION ALLERGIES: ***(List all known)*** _____

_____

DESCRIBE REACTION AND MANAGEMENT OF THE REACTION: _____

_____

FOOD ALLERGIES: ***(List all known)*** _____

_____

_____

DESCRIBE REACTION AND MANAGEMENT OF THE REACTION _____

_____

OTHER ALLERGIES: ***(Include insect stings, hay fever, asthma, animal dander, etc.)*** _____

_____

_____

DESCRIBE REACTION AND MANAGEMENT OF THE REACTION _____

_____

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Medications Name: _____

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely.

❒ This person takes NO medication on a routine basis ❒ This person takes medication as follows:

medication #1 dosage _____

reason for taking _____

medication #1 dosage _____

reason for taking _____

medication #1 dosage _____

reason for taking _____

medication #1 dosage _____

reason for taking _____

medication #1 dosage _____

reason for taking _____

General Questions *(Indicate by circling Y for yes, N for no. Explain "yes" answers below.)*

Has/Does participant:

Y / N 1. Had any recent injury, illness or infections disease?
Y / N 2. Have a chronic or recurring illness/condition?
Y / N 3. Ever been hospitalized?
Y / N 4. Ever had surgery?
Y / N 5. Have frequent headaches?
Y / N 6. Ever had a head injury?
Y / N 7. Ever been knocked unconscious?
Y / N 8. Wear glasses, contacts or protective eye wear?
Y / N 9. Ever had frequent ear infections?
Y / N 10. Ever passed out during or after exercise?
Y / N 11. Ever been dizzy during or after exercise?
Y / N 12. Ever had seizures?
Y / N 13. Ever had chest pain during or after exercise?
Y / N 14. Ever had high blood pressure?
Y / N 15. Ever been diagnosed with a heart murmur?
Y / N 16. Ever had back problems?
Y / N 17. Ever had problems with joints (e.g. knees, ankles)?
Y / N 18. Have an orthodontic appliance being brought to campus?
Y / N 19. Have any skin problems (e.g., itching, rash, acne)?
Y / N 20. Have diabetes?
Y / N 21. Have asthma?
Y / N 22. Had mononucleosis in the past 12 months?
Y / N 23. Had problems with diarrhea/constipation?
Y / N 24. Have problems with sleepwalking?
Y / N 25. If female, have an abnormal menstrual history?
Y / N 26. Have a history of bed-wetting?
Y / N 27. Ever had an eating disorder?
Y / N 28. Ever had emotional difficulties for which professional help was sought?

please explain "yes" answers here, noting the number of the questions: _____

_____

_____

_____

_____

Name of Student's physician/doctor's office and phone #: _____

Date of student's last Tetanus: _____