Program: 2019-2020 Academic Year
From: Health Services
Re: Health Records: Report of Health History

To the student: YOU HAVE BEEN ACCEPTED. This form is to collect important health information about you to provide comprehensive care in Health Services. This information does not influence your standing at the College. It is necessary for the clinical management of your health while enrolled. Release of this information requires informed consent from the student. Please be as thorough and honest as possible.

Last name	First name	Middle	(Chosen Name)	Birth Date	Age
Home Address (# Street/Apt)		City	State		Zip
Home Phone#	Mobile Phone #	Email	Citizenship	Gender Identity	
Health Insurance Provider					
Subscriber's Name		Cert #	Group #:		

Family History & Information

Parent #1 Name	Home Phone #	Mobile Phone #	Email
Parent #1 Home Address (if different from above)	City	State	Zip
Parent #2 Name	Home Phone #	Mobile Phone #	Email
Custodial Parent/Guardian or Emergency Contact #2	Phone #	Email	
Parent #2	City	State	Zip

Student Health Care Provider

Health Care Provider's Name		Provider Phone #	
Health Care Provider's Address	City	State	Zip

Emergency Contacts

Emergency Contact #1 Name	Phone #	Email	Relationship
Emergency Contact #2 Name	Phone #	Email	Relationship

	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
Parent 1					
Parent 2					
Sibling					
Sibling					

Family History - Have any of your blood relatives had any of the following:

	✓	Relationship		✓	Relationship
Alcohol/Drug Abuse			Headaches		
Allergies			Heart Disease		
Arthritis			High Blood Pressure		
Asthma			Kidney Disease		
Cancer			Intestinal Problems		
Cholesterol problem			Learning Disability		
Depression			Lung Disease/TB		
Diabetes			Stomach Disease		
Epilepsy/Convulsions			Stroke		

Personal History - Have you ever been treated for (check all that apply):

	✓		✓		✓
1. ADD/ADHD		20. Eating Problems/Disorder		39. Mononucleosis	
2. Autism		21. Eye Problems		40. Muscle/bone problems	
3. Anemia		22. Elevated Cholesterol		41. Neurological problems	
4. Anxiety		23. Fainting /Blackouts		42. Pneumonia	
5. Arthritis or joint disease		24. Foot trouble		43. Pregnancy	
6. Asthma		25. Hay Fever		44. Rheumatic Fever	
7. Back problems		26. Head injury		45. Scarlet Fever	
8. Bipolar		27. Headaches		46. Sexually Transmitted Disease	
9. Blood disorders		28. Heart problems		47. Sickle Cell Disease/trait	
10. Breathing/lung problems		29. Hemorrhoids		48. Sinus problems	
11. Cancer or tumor		30. Hepatitis A, B or C		49. Skin problems	
12. Chicken Pox		31. Hernia		50. Substance use/abuse	
13. Constipation/diarrhea		32. High Blood Pressure		51. Throat problems	
14. Convulsions/Seizures		33. HIV		52. Thyroid disorder	
15. Dental problems/gum disease		34. Immune disorder		53. Tuberculosis	
16. Depression, major depression		35. Insomnia		54. Urinary Tract Infection	
17. Diabetes		36. Infectious disease, major		55. Weight concerns/problems	
18. Digestive problems		37. Kidney Disease/problems			
19. Ear trouble/Hearing loss		38. Lung problems			

Please explain any positive answers above by using #:

Allergies & Sensitivities

Drug allergies or sensitivities (list):

Food allergy (list):

Environmental allergy (list):

Other allergy or sensitivity (list):

What is your learning difference?

Surgical history - Please list any surgeries you have had:

Hospitalization: Have you ever been hospitalized for a medical or mental health reason? ☐ YES ☐ NO If YES, please explain:

Mental Health: Have you ever ben in counseling or therapy? ☐ YES ☐ NO If YES, please explain:

Self-Care & Health Habits

When was your last dental check-up?

Do you use tobacco products? ☐ YES ☐ NO Times per day: # of years:

Describe your caffeine intake of coffee, tea or soda in servings per day:

Do you drink alcohol? ☐ YES ☐ NO If YES, how much per day/week:

Do you use recreational drugs? ☐ YES ☐ NO If YES, please name the type and frequency.

Have you struggled with addiction? ☐ YES ☐ NO

Do you participate in physical activity? ☐ YES ☐ NO If YES, please describe:

Past Injuries - Do you have (or have you ever had), the following:

	✓	When	Explain
Concussion(s) / Head Injury			
Neck or Spine Injury			
Arm/Wrist/Hand/Elbow Injuries			
Chest/Rib Injury			
Hip/Leg/Knee Injury			
Foot/Ankle Injury			

Prescription Medications, Vitamins & Supplements (name, dose & times/day):

Medication Name:	Dosage	Times per day

Acknowledgements

I hereby certify that this form is complete to the best of my knowledge.

Student Signature Date

Student's Bill of Rights

As a student, I understand I have the right…

1. to be treated with dignity and respect by all those who serve me.
2. to a plan of care that is designed to meet my individual needs.
3. to participate in the development of my care.
4. to have my plan of care evaluated and updated periodically
5. to expect that all personnel who care for me will be current in the skills and knowledge of their field of employment.
6. to expect that those providing my care will receive supervision and direction from qualified persons on an ongoing basis.
7. to expect proper identification by name and title of those persons who care for me.
8. to know that case-related information will be kept confidential and may not be released to anyone (including parents/guardians) without my written authorization.
9. to review my record of care at any time.
10. to refuse treatment.
11. to be served without regard to race, color, religion, national origin, sex, age, veteran or handicapped status.

I have read the above Student's Bill of Rights.

Student Signature Date

Consent for Health and Counseling Services Information Sharing

Landmark College Health and Counseling Services recognizes the close ties between students' physical and emotional well-being. For this reason, it can often be a helpful and effective strategy for Landmark College counselors and Health Services practitioners to collaborate regarding your treatment. With your consent, your Landmark College counselor and Landmark College health care provider may exchange your medical and/or mental health information and discuss your treatment. If you prefer not to give consent, you may also leave this space blank.

Student Signature Date

Consent Form for Permission to Provide Medical Treatment

I give the college health center personnel permission to threat me for routine illness, chronic conditions and injuries in collaboration with myself. I understand that Health Services is governed by laws regarding confidentiality and release of medical information. Health Services uses an external lab for blood and urine testing. I understand that liability for that agency does not fall under the same liability for Health Services on campus. I understand that clinicians must follow reporting requirements of positive lab tests deemed necessary by federal and state health officials.

For minors (under the age of 18) the parent/guardian signature below gives permission to the physician(s) selected by the College to hospitalize, secure proper medical treatment, and to order injections, anesthesia, and/or surgical procedures for the student named above (in the event that parent/guardian cannot be reached in an emergency).

Student Signature Date

Parent/Guardian Signature (if student is under 18) Date

Authorization to Exchange Information and Health Records

For the purpose of continuity of treatment and care after discharge, I hereby authorize the Landmark College Health Services Office to obtain all treatment records, summaries, and aftercare recommendations from the Brattleboro Memorial Hospital and Brattleboro Memorial Hospital Emergency Room for any treatment received while I am enrolled as a student. I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. Release of confidential information is subject to State and Federal laws. Unless this consent form is sooner revoked by the undersigned, it will be in effect while this student is enrolled at the college.

Student Signature Date

Parent/Guardian Signature (if student is under 18) Date