Program: 2019 Preparing Students for College Success

From: Office of Health Services - JWU-Denver

Re: Health History & Examination Form (Page **1** of **4**)

A copy of the front and back of a health insurance card must be attached to this form.

Last name	First name	Middle	(Chosen Name)	Birth Date	Age
Home Address (# Street/Apt)		City	State		Zip
Student's Social Security #		Gender			
Custodial Parent/Guardian or Emergency Contact #1			Phone #	Email	
Parent/Guardian Home Address (if different from above)		City	State		Zip
Business Address (# Street/Apt)	City	State	Zip	Phone	
Custodial Parent/Guardian or Emergency Contact #2			Phone #	Email	
Parent/Guardian Home Address (if different from above)		City	State		Zip
Business Address (# Street/Apt)	City	State	Zip	Phone	
If Not Available in an Emergency, Notify: (First Name, Last Name)		Phone #	Email	Relationship	
Emergency Contact Home Address (# Street/Apt)	City	State	Zip	Phone	

Required Insurance Information

Health Insurance Provider		
Subscriber's Name	Cert #	Group #:

Parent/Family/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 hereby give permission to the college to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routing tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the college to arrange necessary related transportation for my student. 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/family/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 provided to Landmark's health personnel upon participant's arrival. Provide complete information so that the college can be aware of your needs.

Medication Allergies: List all known; describe reaction & management of reaction

Food Allergies: List all known; describe reaction & management of reaction

Other Allergies (insect stings, hay fever, asthma, animal dander, etc): List all known; describe reaction & management of reaction

Medication Being Taken

Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ***Please attach additional pages if necessary.***

☐ This person takes **no medication** on a routine basis.
☐ This person **takes medication** as follows:

Medication #1 Dosage Specific Times Taken Each Day

Reason for taking

Medication #2 Dosage Specific Times Taken Each Day

Reason for taking

Medication #3 Dosage Specific Times Taken Each Day

Reason for taking

Medication #4 Dosage Specific Times Taken Each Day

Reason for taking

Medication #5 Dosage Specific Times Taken Each Day

Reason for taking

Does this person take medications on weekends or on as "as needed" basis?

Weekends: ■ yes ☐ no As Needed: ☐ yes ☐ no

Explain:

General Questions (Explain "Yes" Answers Below.)

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

Medication Allergies: List all known; describe reaction & management of reaction

Please provide any additional information about the participant's physical, behavioral or mental health.

Have we forgotten to ask about anything?

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. *A Health exam is required within 24 months prior to attending program. A new exam is not necessarily required unless medical status has changed*.

Blood Pressure: Weight: Height:

The applicant is under my care for the following conditions:

In my opinion, the above applicant ☐ is ☐ is not able to participate in campus activities.

Recommendations and Restrictions

Treatment to be continued during the 3-week program:

Medications to be administered during the 3-week program (name, dosage & frequency)

Any medically prescribed meal plan or dietary restrictions?

Known allergies:

Description of any limitation or restriction of activities:

Additional information for health care staff:

Signature of licensed medical provider

Printed Name Title

Provider Address (# Street/Apt) City State Zip Phone