106 E. Main St.
Spring Arbor, Michigan 49283
Fax (517) 750.6625 Phone (517) 750.6352

The following health history is confidential and does not affect your admission status. This information is requested to determine if you have any medical conditions that may require special assistance from the University. This information will be used to help us provide continuity of care for you. This information will not be released without your written permission except in an emergency situation, by parental consent if under age 18. Please attach additional sheets for any items that require additional explanation.

SECTION 1: REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

LAST NAME FIRST NAME MIDDLE NAME STUDENT ID#

PERMANENT ADDRESS CITY STATE ZIP CODE COUNTRY AREA CODE/PHONE

DATE OF BIRTH (mo/day/yr)________________PLACE OF BIRTH________________GENDER: __ M __ F MARITAL STATUS: ___S ___M ____OTHER

CLASS YOU ARE ENTERING (Circle)
FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE: ___ YES ___ NO
PREVIOUSLY A PATIENT HERE: ___ YES ___ NO

SEMESTER ENTERING (Circle): FALL SPRING
SUMMER 1 SUMMER 2 YEAR: _______

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE

NAME AND ADDRESS OF HEALTH INSURANCE CO.____ AREA CODE/PHONE______________

POLICY HOLDER NAME________________________________ POLICY/ID # _________________________ GROUP # ___________________

POLICYHOLDER DATE OF BIRTH________________________RELATIONSHIP TO STUDENT____

POLICYHOLDER PHONE #_____________________________ADDRESS (IF DIFFERENT THAN STUDENT):____________________________

****PLEASE ATTACH A SCANNED COPY OF YOUR INS. CARD, FRONT AND BACK TO** healthinsinfo@arbor.edu**

SECTION 2: FAMILY MEDICAL HISTORY (Please print in black ink) To be completed by student

HAS ANY PERSON, RELATED BY BLOOD, HAD ANY OF THE FOLLOWING CONDITIONS:

	Y	N	Relationship		Y	N	Relationship		Y	N	Relationship
High blood pressure				Cholesterol or blood fat Disorder				Cancer (Type): ____________			
Stroke				Diabetes				Alcohol/drug problem			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder				Asthma				Suicide			

SECTION 3: PERSONAL MEDICAL HISTORY (Please print in black ink) To be completed by student

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING: PLEASE ANSWER EACH QUESTION AND INDICATE YEAR FOR "YES" ANSWERS

	Y	N	Year		Y	N	Year		Y	N	Year		Y	N	Year
Anemia or Sickle Cell anemia				Chest Pain Or pressure				Headaches (frequent/severe)				Protein or blood In urine			
Anorexia/Bulimia				Chronic Cough				Head Injury (severe)				Chronic pain (severe/recurrent)			
Allergies/Hay fever				Concussion				Hepatitis or jaundice				Pneumonia			
Asthma				Cancer or Tumor				Hearing Loss				Rectal disease			
Arthritis				Smoking				Hernia Specify:_________				Rheumatic or Scarlet fever			
Alcohol/Drug problem				Diabetes Type I or II:_____				Intestinal Problems				Seizures			
Breathing/Bronchitis Problems				Dizziness or Fainting				Kidney Stone				Sexually Transmitted Infection (STI)			
Back or neck Injury				Depression or Excessive worry				Learning Disorder Specify:_________				Thyroid Trouble Or disease			
Bone, joint or Other deformity				Eye problem (not glasses)				Malaria				Tuberculosis			
Broken bone Specify:_________				Easy fatigability				Mononucleosis				Testicle Problems			
Bladder or kidney Infection				High blood Pressure				Menstrual Cramps (severe)				Other Specify:_________			
Blood Transfusion				Heart Condition				Physical Disability Specify:_________				Other Specify: ________			

Describe any conditions or disabilities that would exclude participation in physical education (e.g., swimming). ________________________

Do you exercise three or more times per week? ___ Yes ___ No Do you use a seatbelt on a regular basis? ___ Yes ___ No

Please list any drugs, medicines, birth control pills, vitamins, minerals (prescription and nonprescription or herbal medicines) you use and indicate how often you use them?

Name of drug	Reason for taking drug?	How much are you taking and how often?
1.		
2.		
3.		
4.		

ALLERGIES: Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics Name:__________________________			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals Specify:_________________________			
Insect bites			
Food allergies Name:__________________________			

	Yes	No	Explanation (specify when, where and why)
Have you ever been a patient in any type of hospital?			
Has your academic career been interrupted due to physical or emotional problems?			
Have you ever had any serious illness or injuries other than those already noted?			

IMPORTANT INFORMATION…..PLEASE READ AND COMPLETE

STATEMENT BY STUDENT:

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the the information is strictly confidential and will not be released to anyone without my written consent, except in an emergency or by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Holton Health and Wellness Center to release information from my record to a physician, hospital or other medical agency involved in providing me with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself that may be advised or recommended by the providers of the Holton Health and Wellness Center.

____ _______________________________

Signature of Student **Date**

PARENTAL/GUARDIAN PERMIT – MUST BE COMPLETED IF STUDENT IS UNDER 18 YEARS OF AGE

The LAW requires that parental permission be obtained for medical treatment of minors. A parent or guardian should sign the following consent form so that medical treatment may be given to the student who is a minor. However, no major operation will be performed except in extreme emergency, without parent/guardian being contacted and fully informed.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my daughter/son/ward.

(Signed)_______________________________________(Relationship)____________________________(Date)___________________________

Submit completed form online, fax, scan to email, or send all information to
Spring Arbor University Holton Health and Wellness Center
106 E. Main St. Spring Arbor, Michigan 49283
Phone (517) 750.6352 / Fax (517) 750.6625 / Email: holtonhealth@arbor.edu