



Wellness & Health Center (WHC)

1700 South Main Street
Goshen, IN 46526

Phone: 574.535.7474 or 800.348.7422 • Fax: 574.535.7195
health@goshen.edu

Name: _____ Date of birth: ____/____/____
Print name MM DD YY

Student ID Number: _____

PERSONAL HEALTH HISTORY

Answer all questions yes or no. Comment on all yes answers in below designated area or on additional paper.

	yes	no		yes	no		yes	no
ADD/ADHD			Eating Disorder			Menstrual Problems		
Alcohol/Substance Abuse			Epilepsy/Seizure Disorder			Migraine/Frequent Headaches		
Allergies			Eye Problem			Mononucleosis		
Anemia/Bleeding Disorders			Fainting/ Dizziness			Physical Disability		
Anxiety			Head Injury			Pneumonia		
Asthma			Heart Disease/ Heart Murmur			Sexually Transmitted Disease		
Back Pain or Problems			Heat Cramps/ Heat Illness			Shortness of Breath		
Bone or Joint Problems			Hepatitis			Skin Problems		
Cancer			High Blood Pressure			Stomach/Gastrointestinal Problems		
Chest Pain			HIV/AIDS			Thyroid/ Endocrine Disorders		
Concussion			Immune Disorder			Tobacco Use		
Depression			Kidney/ Bladder Problems			Tuberculosis or positive TB test		
Diabetes			Malaria			Weight Gain or Loss		
Ear, Nose, Throat Problems			Meningitis					

OTHER INFORMATION

1. Explain yes answers above: _____

2. List any ongoing problems which are being monitored or for which you are receiving treatment: _____

3. List all Medications and supplements that you take, with or without a prescription: _____

4. Drug/Medication Allergies: _____

5. Other Allergies: *(Please list all other allergies, such as peanuts, mold, bee stings, etc.)* _____

6. Surgeries/Hospitalizations: *(Please explain and indicate Month/Year for each)* _____

7. Chronic Health Problems: _____

8. Is there any other information that would be helpful for the Health Center to know? *(Please attach additional page if needed)* _____



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IMMUNIZATION RECORD

This requirement may be met in one of two ways.

1. Have a health care provider complete this form and sign and date below.
2. Obtain a copy of your **complete** immunization record from your health care provider's office, high school, college or health department and attach it to this form.

Please read carefully as you may need a booster to meet requirements.

REQUIRED IMMUNIZATIONS (Enter dates by Month, Day, Year)

This information is required by Goshen College in compliance with the law set forth by the State of Indiana. If not completed, a restriction will be placed on the student's registration until the form is completed and submitted. **Enter dates by Month, Day, Year.**

ALL STUDENTS

Measles-Mumps-Rubella (MMR) *Two doses required after first birthday if born after 1956.*

1. ____/____/____ 2. ____/____/____

Tetanus-Diphtheria-Pertussis Series (DPT, Td, DTap) *Minimum of 3 doses*

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____

Booster within last 10 years Td or Tdap 1. ____/____/____

Polio Series *Minimum of 3 doses*

1. ____/____/____ 2. ____/____/____ 3. ____/____/____ 4. ____/____/____ 5. ____/____/____

INTERNATIONAL STUDENTS ONLY

Tuberculosis Screening REQUIRED: *Tuberculosis screening must be done in the United States upon arrival to campus. Further evaluation may be needed.*

Date Administered: ____/____/____ Date read: ____/____/____ Reaction in Millimeters _____

HIGHLY RECOMMENDED IMMUNIZATIONS (Enter dates by Month, Day, Year)

Varicella (Chicken Pox) History of disease? Date (year): _____ or Vaccination dates: 1. ____/____/____ 2. ____/____/____

Meningococcal Vaccine 1. ____/____/____

Hepatitis A 1. ____/____/____ 2. ____/____/____

Hepatitis B 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

Gardasil (HPV) for females only ages 9-26 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

Health Care Provider's Name: _____
Signature Print

Date: ____/____/____ Telephone number: (____) _____

APPROVAL, CONSENT FOR TREATMENT AND MENINGITIS REVIEWED:

- I hereby state that, to the best of my knowledge, my answers on all three pages are complete and correct.
- I give consent for medical services, procedures, authorize and consent to treatment; I understand that I may withdraw my consent at any time.
- I have read and understand the information about Meningitis on first page of this document.
- Should I be under eighteen years of age, my parent's (or guardian's) signature below indicates approval and consent for medical treatment deemed necessary.

Student Signature Date Parent Signature Date (MUST be signed by parent if student is under 18)