GOSHEN COLLEGE

Health Services
1700 S. Main St. Goshen, IN 46526
800.348.7422 | 574.535.7474 | Fax: 574.535.7195

health@goshen.edu | goshen.edu/health

Confidential Health Form

Welcome to Goshen College. In order to meet your health needs, Goshen College has contracted with Goshen Family Physicians (GFP) for professional services. To find more information please go to **www.goshen.edu/health.**

Instructions:

1. **Please complete all 3 pages.** Print Clearly. **Sign** page 3. Use month/day/year format.
2. **Parent signature needed on page 3 for students under 18.**
3. This form must be completed and turned in to Health Services before you can register for classes.
4. Student's seeking a medical or religious exemption for immunizations must complete an appropriate form at HS.
5. When completed, either mail to Health Services at the address above or bring to our office.

The information provided serves as treatment records for the purpose treating students while they are enrolled at Goshen College. This information falls under the overall understanding of educational records and the Federal Education Rights and Privacy Act (FERPA).

Personal Information:

Name: _____
Last First Middle Student ID Number

Date of birth: _____ / _____ / _____ Gender: ❑ M ❑ F Social security number: _____ - _____ - _____
MM DD YY

Permanent address: _____

City: _____ State: _____ Zip/Country: _____

Home phone: (_____)_____ Student's cell phone: (_____)_____

Name of parent(s)/guardian: _____

Person to notify in case of an emergency:

Emergency contact name: _____ Relationship: _____

Address: _____ City: _____ State: _____

Home Phone: (_____)_____ Work phone (_____)_____ Cell phone: (_____)_____

All students must read and sign bottom of last page:

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in the US. Meningitis is an infection of the fluid surrounding the brain and spinal cord. About 1,000 – 2,600 people get meningococcal disease each year in the US. Even when they are treated with antibiotics, 10-15% of these people die. Of those who survive, another 11-19% loss their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or stroke.

Anyone can get meningococcal disease. College freshman who live in dormitories, and teenagers 15-19 have an increased risk of getting meningococcal disease. Preventing the disease through use of meningococcal vaccine is important for people at risk. The risk of meningococcal vaccine causing serious harm is extremely low. The Centers for Disease Control and Prevention (CDC) recommends that college freshman should get the vaccine, if they did not get it as a routine preadolescent immunization. For additional information please go to **http://www.cdc.gov/meningitis/index.html.**

Student's full name: _____
(Print name)

Date of birth: _____ / _____ / _____ Student ID number: _____
MM DD YY

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 Health Services or GFP to know?
(Please attach additional page if needed)

Student's full name *(print)* : _____

Date of birth: _____ / _____ / _____ Student ID number: _____

MM DD YY

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

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

1. **Measles-Mumps-Rubella (MMR):** #1 ____ / ____ / ____ #2 ____ / ____ / ____
   Two doses required after first birthday if born after 1956.
2. **Tetanus-Diphtheria-Pertussis Series (DPT, Td, DTap)** (Minimum of 3 doses):

   #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3 ____ / ____ / ____ #4 ____ / ____ / ____ #5 ____ / ____ / ____

   Booster within last 10 years - Tdap: #1 ____ / ____ / ____
3. **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

4. **Varicella (Chicken Pox):** History of disease? Date (year): _____

   OR
5. **Varicella vaccination dates:** #1 ____ / ____ / ____ #2 ____ / ____ / ____
6. **Meningitis A:** #1 ____ / ____ / ____ #2 ____ / ____ / ____
7. **Meningitis B:** #1 ____ / ____ / ____ #2 ____ / ____ / ____
8. **Hepatitis A:** #1 ____ / ____ / ____ #2 ____ / ____ / ____
9. **Hepatitis B:** #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3____ / ____ / ____
10. **Gardisil (HPV)**: #1 ____ / ____ / ____ #2 ____ / ____ / ____ #3____ / ____ / ____

Health Care Provider's Name *(print)*: _____ Telephone: (_____)_____

Signature: _____ Date: _____

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)