HEARTLAND CHRISTIAN • COLLEGE

Student Health Form

Personal Information

Name _____
Date of Birth ____/____/____
Social Security Number _____
Student's Cell Phone (____) _____
Street Address _____
City/State/Zip _____
Country _____
Insurance Company _____
Insurance Policy # _____

Emergency Contact Information

Person to notify in the case of an emergency
_____
Relationship _____
Phone (____) _____
Physician's Name _____
Physician's Phone (____) _____
Physician's Address _____
_____

Personal Medical History

Allergies to Medications: ❑No ❑Yes, Explain _____
_____
Do you carry an Epipen? ❑No ❑Yes, Explain _____

(Please check "yes" or "no" if you have had any of the following)

	Yes	No		Yes	No
Allergies			Eating Disorder		
Asthma			Insomnia/Sleep Disorder		
Siezures			Depression		
Diabetes			Panic Attacks/Anxiety		
Tuberculosis			Schizophrenia		
Cancer			Bipolar Disorder		
Hepatitis			Suicidal Thoughts/Attempts		
Eye/Visual Impairment			Alcohol/Chemical Dependency		
Ear/Hearing Impairment			Other Mental Health Condition		
High Blood Pressure			Sexually Transmitted Disease		
Cardiovascular Disease/Problems					

If answered "yes" to any of the above, please explain: *attach extra sheet if necessary* _____
_____

Have you had an illness, injury or hospitalization not listed above? ❑No ❑Yes, Explain
_____

ALL Medications must be declared.
List all prescription medications taken on a regular basis: *attach extra sheet if necessary*

Name of Medication	Dosage	Times Per Day	Reason for Taking

Continued on next page

Tuberculosis Test

TB tests are required for students who were born outside the U.S. or who have lived outside the U.S. within the past 12 months.

Skin Test Date administered ____/____/____ Date read ____/____/____ Result: Pos./Neg.

Chest x-ray (required if skin test is positive) Date read ____/____/____ Result: Pos./Neg.

Immunization Records

Required Immunizations:

MMR (Measles, Mumps and Rubella/German Measles)
Dose #1 Date ____/____/____ Dose #2 Date ____/____/____ or Measles Date ____/____/____

Hepatitis B
Dose #1 Date ____/____/____ Dose #2 Date ____/____/____ Dose #3 Date ____/____/____

Meningococcal Vaccine: *Required if living in Campus Housing*
MPSV or MCV4 Date administered ____/____/____

Recommended Immunizations:

Varivax (Chickenpox Vaccine): *Two doses required if vaccinated*
Dose #1 Date ____/____/____ Dose #2 Date ____/____/____ or Disease Date ____/____/____

Tetanus Diphtheria: Date administered ____/____/____
If received more than 10 years ago, student is strongly encouraged to receive a booster

Please attach a copy of original immunization record or high school immunization record for verification.

Statements of Agreement

I certify that the information I have provided is truthful and accurate to the best of my knowledge.

In case of medical emergency, where I am unable to give permission for treatment, I authorize Heartland Christian College staff to take whatever steps may be necessary to address my medical emergency. I also grant permission to Heartland Christian College staff to contact my parent, emergency contact, and my physician. If a life-threatening emergency exists, staff may do any or all of the following: Call another physician or the paramedics, call an ambulance, or take the student to an emergency medical unit.

Any expenses incurred will be the responsibility of the student and/or legal guardian.

I have read this entire release and verify its accuracy. I agree to hold harmless Heartland Christian College, its employees, and agents from all claims and demands resulting from an emergency situation.

_____ Date _____
Student Signature