ANTIOCH UNIVERSITY

ANTIOCH COLLEGE
WINGFIELD HEALTH CENTER
795 Livermore Street
Yellow Springs, OH 45387
937-769-1198

ANTIOCH COLLEGE STUDENT HEALTH FORM

Entering students are required to provide the following medical history. Students must also have a physical exam and immunization history completed and signed by their health-care provider. This information is for our Health Center's use only to aid in providing you health care and will not be released without your knowledge and consent. Please complete the medical history below and then have your health-care provider complete the Physical Examination and Immunization Record forms. Please return all the forms to the Admissions Office by August 1, 2006.

PERSONAL INFORMATION

Name: _____ Entering: Fall 200_ / Spring 200_
Last First Middle

Preferred name:_____

Address: _____
Street City State Zip

Date of Birth: _____ Social Security Number: _____
Month / Day / Year

Person to notify in case of an emergency: _____

Relationship to you: _____ Address: _____

Home Phone: _____ Business Phone: _____

FAMILY HEALTH HISTORY

Have any family members ever had any of the following:

Condition	Yes	Relationship	Condition	Yes	Relationship
Anxiety			Heart Disease		
Asthma			High Blood Pressure		
Arthritis			Kidney Disease		
Alcohol or drug dependency			Migraines		
Bipolar illness			Schizophrenia		
Blood Disease / kind:			Seizures		
Cancer / kind:			Suicide		
Depression			Stroke		
Diabetes			Tuberculosis		

	Name	Age	State of Health	Age at Death	Cause of Death
Parent/Guardian					
Parent/Guardian					
Sibling					
Sibling					
Sibling					

PERSONAL HEALTH HISTORY

Please evaluate your general health: Excellent Good Fair Poor

Indicate if you have, or have ever had, any of the following conditions: *

Anemia	Drug / Alcohol Dependency	Malaria
Anxiety	Eating Disorder	Menstrual Cramps
Arthritis	Ear Infections	Mononucleosis
Asthma	Eye / Visual Impairment	Pneumonia
Back Problems	Gynecological Problems	Polio
Bipolar Illness	Headaches	Rheumatic Fever
Bone Disease	Head Injury	Seizures
Cancer	Heart Disease	Sexually Transmitted Disease
Cerebral Palsy	Hepatitis / Liver Disease	Skin Problems
Chicken Pox	Hernia	Suicide Attempt
Chronic Fatigue Syndrome	High Blood Pressure	Sun Sensitivity / Sun Stroke
Chronic Pain	HIV / AIDS	Thyroid Disease
Deafness / Hearing Loss	Insomnia	Tuberculosis
Depression	Irritable Bowel Syndrome	Ulcer
Diabetes	Kidney Disease	Urinary Tract Infection
Dizziness / Vertigo	Learning Disability	Other:

**Please provide detailed information on all positive responses. Indicate, also, when the medical condition or symptom occurred and if the condition is current. Use an additional sheet of paper, if necessary.*

Please describe any other illness, medical problem, hospitalization, or surgery not identified above, including when it occurred and if the condition is current.

Are you allergic to any medications? If yes, what medication(s) and what is your reaction?

List any medications and/or treatments you are using, including psychiatric and over-the-counter medication.

Medication Condition Dosage Current Side Effects

_____
_____
_____
_____
_____
_____

Are you allergic to dust, molds, pollens, insect stings? If yes, what?
Explain the severity and means of treatment.

Have you any food allergies or other dietary restrictions? If yes, what?

Have you lived or traveled overseas? Where? When?

Has your physical ability been restricted during the past 5 years, including your ability to run, lift, and climb?
Is it now restricted? Give details, including the reason and duration.

Do you wear glasses or contact lenses? Which, and for what reason?

Have you ever been under the care of a psychologist, psychiatrist, or counselor? If yes, when?
For what reason?

Is there anything else about you that you would like us to know in order to provide for your health care?

Personal Physician_____ Telephone_____
Personal Dentist_____ Telephone_____
Counselor/Psychiatrist_____ Telephone_____

Immunization Record	Please print in black ink. To be completed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form. Student signature (or parent signature if student is under 18) is required.

Last Name	First Name	Middle Name	Date of birth (m/d/yr)	*Social Security Number

Section A Required Immunizations	**month/day/year**	**month/day/year**	**month/day/year**	**month/day/year**
· DTP or Td	#1.	#2.	#3.	#4.
· Td Booster				
· Polio				
· MMR (after first birthday)				
· Measles (after first birthday)				Titer Date and Result
· Mumps				Titer Date and Result
· Rubella				Titer Date and Result

Section B Recommended Immunizations

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.
In accordance with Ohio Revised Code, Section 3701.133, (B), students are required to disclose whether they have been vaccinated against Meningococcal Disease (meningitis) and Hepatitis B, in order to live in on-campus housing.

Recommended Immunizations	**month/day/year**	**month/day/year**	**month/day/year**	**month/day/year**
· Hepatitis B Series				Titer date and result
· Meningococcal				
· Varicella (chicken pox) series of two doses or immunity by positive blood titer				Titer Date and Result
· Tuberculin (PPD) Test Date read · (within 12 months) mm induration				
· Chest X-ray, if positive PPD Date Results				
· Treatment, if applicable Date				

Section C Optional Immunizations	**month/day/year**	**month/day/year**	**month/day/year**
· Haemophilus influenzae type b			
· Pneumococcal			
· Hepatitis A series			
· Typhoid (specify type)			
· Other			

Signature or Clinic Stamp **REQUIRED:**

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____ _____
Print Name of Physician/Physician Assistant/Nurse Practitioner Area Code / Phone Number

_____
Office Address City State Zip Code

Signature of Student (or Parent, if Student is under age 18) _____

* Provision of Social Security Number is voluntary, is requested solely for administrative convenience and record keeping accuracy, and is requested only to provide a personal identifier for the internal records of the institution.

PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____
Last First Middle Month / Day / Year

Gender: Female ___ Male ___ Height:_____inches Weight:_____lbs

Corrected Vision: Right: 20/____ Left: 20/____ Color Vision: ____Normal ____Abnormal

Blood Pressure (sitting): Right Arm _____ Left Arm _____ Pulse (resting): _____

Required for females: HGB: _____ Gm. Or HCT: _____ %

Urinalysis: _____ Normal Abnormalities: _____ Sugar _____ Albumin _____ Micro

Are there irregularities in the following systems:

	Normal	Abnormal
Head, Ear, Nose, or Throat		
Eyes (other than acuity)		
Endocrine		
Respiratory		
Hernia		
Neuropsychiatric		
Cardiovascular		
Skin/Teeth		
Gastrointestinal		
Musculoskeletal		

Weight loss or gain of > 10 pounds in the last year? ____ Yes ____ No

Is there loss or seriously impaired function of any paired organ? ____ Yes ____ No

Is the student now under treatment or do you recommend care for any physical or emotional problem? __ Yes __ No

Recommendations for physical activity and physical education: _____Limited _____Unlimited

Please explain limitations: _____

_____

_____ _____
Signature of Physician Date

_____ _____
Print Name of Physician Area Code / Phone Number

_____
Office Address City State Zip Code

PLEASE RETURN BY AUGUST 1, 2006 TO ADMISSIONS OFFICE, ANTIOCH COLLEGE, 795 LIVERMORE STREET, YELLOW SPRINGS, OH 45387