

McDaniel College Student Health Services Medical Record

This form **MUST** be completed by each full-time student who enters McDaniel College. Failure to do so will delay your registration at the College. Please answer all questions. The information you provide is confidential and is strictly for the use of Student Health Services as an aid in providing necessary health care to you while a student. No information will be released to anyone without your knowledge or consent. Direct questions to 410/857-2243.

Last Name		First Name		Middle Initial	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address				Country	
City, State, Zip		Home Phone		E-Mail	
Cell Phone		Social Security Number		Date of Birth	
Family Physician		Address			
City		State	Phone	Fax	
In Emergency, notify					
Name		Relationship		Home Phone	
Address		Cell Phone		Work Phone	

PERSONAL HISTORY Check "yes" or "no". Circle appropriate condition. For "yes" responses, explain below.

Allergy to Medication/Other (List): <input type="checkbox"/> Yes <input type="checkbox"/> No		Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	*Mental Health In-/Out-Patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fainting or Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	*Frequent Anxiety/Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems/ Recurrent UTI's		Heart problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	*Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No		Hayfever or Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	*Attention Deficit Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deafness/Hearing Loss		Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alternative Medical Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drug or Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech Problems		*Hospitalization/Surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		*Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Serious Injury to: Head, Neck, Back or Extremity					
<input type="checkbox"/> Yes <input type="checkbox"/> No					

Comments or additional information:

Do you take any medications on a regular basis, or as needed? (Prescription, over the counter, herbals, vitamins) please list:

Do you have any continuing medical or mental health issues? (Explain)

*Treating Physicians and/or Psychiatrist	Phone
Insurance Company Name	Name of Policy Holder
Insurance Company Policy #	Group #
Address of Insurance Company	Phone

**(Include a copy of the front and back of your insurance card.) Parents might want to consider McDaniel Insurance because of pre-existing HMO limitations.*

Student's Signature _____ Date _____
If you are under the age of 18 at the time of enrollment, it is imperative that Student Health Services have your parent's or guardian's permission to provide medical care until you reach your 18th birthday. Please have one or both of them sign the consent form at the bottom of this page.

PARENTAL PERMISSION TO TREAT MINORS:
I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student and also to present information concerning his/her medical condition to responsible College officials when deemed desirable. No major operation will be performed, except in extreme emergency, without the parent or guardian being contacted and fully informed.

Signed _____ Relationship _____

MENINGOCOCCAL VACCINE WAIVER

I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is a rare but life threatening illness. I understand that Maryland law requires that an individual enrolled in an institution of higher education in Maryland who resides in on-campus housing shall receive vaccination against meningococcal disease unless the individual signs a waiver to the vaccination. I choose to waive receipt of meningococcal vaccine.

Student's Signature _____ Date _____
(or parent if student is under 18)

McDaniel College Health Form – MANDATORY PHYSICAL ASSESSMENT

RETURN THIS FORM TO: Student Health Services, McDaniel College, 2 College Hill, Westminster, MD 21157-4390 or fax to 410-857-2703 (secure fax). No sport participation until this Health Form is on file with Student Health Services. **NO EXCEPTIONS.**

Physical Examination (This part is to be completed by a Physician)

Name _____			
Age _____	Height _____	Weight _____	
Blood Pressure _____		urine: multi stix _____	
Vision: Right 20/ _____	Left 20/ _____	with correction _____	without correction _____

REQUIRED IMMUNIZATIONS: **Mandatory** (If not current, administer shots)

	Date of Last Injection	
Diphtheria		PPD is Mandatory <i>(Required within one year prior to admission)</i> Date _____ Result _____ (mm reading) If result is 10mm or greater, chest x-ray required: Date _____ Result _____ (in English)
Tetanus (within last 10 years)		
Polio (series completed?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MMR #1 (12 months or later)		
MMR #2		
Meningococcal Vaccine (or waiver signed on reverse side)		
Chicken Pox Vaccine or Titre (proof of disease)		
Hepatitis B Series #1		
Hepatitis B Series #2		
Hepatitis B Series #3		
RECOMMENDED: Hepatitis A		

Are there abnormalities of the following systems? Describe fully. Use additional sheet if necessary

Head, Ears, Nose, or Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurologic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metabolic/endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Appearance	<input type="checkbox"/> Yes <input type="checkbox"/> No

Practitioner's Signature _____
Print Name _____
Date _____
Address _____
Telephone _____ Fax _____

Recommendations for physical activity (PE, Intramural, ROTC) <input type="checkbox"/> Unlimited <input type="checkbox"/> Limited Explain: _____ _____ _____ Do you have any recommendations regarding the emotional or physical care or housing requirements of this student? Explain: _____ _____ _____ Is the student now under treatment for any medical or emotional condition? Explain: _____ _____ _____ _____
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