



MCDANIEL COLLEGE

The Wellness Center
Winslow Center
2 College Hill
Westminster, MD 21157
410-857-2243 Fax : 410-857-2703

OFFICE USE ONLY:

Date Entered: _____

Student ID #: _____

Housing

Commuter

ALL FULL TIME STUDENTS

Student Health Forms must be completed and returned by **July 15th for Fall** entrance, and **Jan 2nd for Spring** entrance.

GENERAL INFORMATION

Name: _____ Social Security No. _____
Last First Middle

Address: _____
Number and Street City State Zip Code

Home Phone: _____ Cell Phone: _____
Area Code Area Code

Date of Birth: ____/____/____ Sex: Male Female

Term Entering: Fall _____ Spring _____ Transfer _____
Year Year Year

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Area Code Area Code Area Code

CONSENTS

RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize McDaniel College to disclose information on the health forms to any Health Care Provider who has rendered medical services to me.

 Student Signature Date _____

 Parent/Legal Guardian Signature, if student is under 18 years of age. Date _____

PARENTAL CONSENT FOR MEDICAL TREATMENT OF MINOR (Younger than 18 upon arrival on campus):

I hereby authorize my son/daughter to be treated in the McDaniel College Wellness Center if needed, and in case of emergency and in the event that I am unavailable, to be taken to the nearest emergency care center or hospital for treatment.

 Parent/Legal Guardian Signature, if student is under 18 years of age. Date _____

Insurance Company _____ Name of Policy Holder _____

Insurance Policy Number _____ Group Number _____

Address to send claims _____

INSURANCE CARD INFORMATION: Please attach a copy of your Insurance Card (front and back).

Last Name

First Name

MI

DOB

MANDATORY FOR McDANIEL COLLEGE REGISTRATION

PERSONAL MEDICAL HISTORY

| | | | |
|--|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bronchitis (Chronic) | <input type="checkbox"/> Hearing Loss/Deafness | <input type="checkbox"/> Major Surgeries (specify) |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Peptic Ulcer disease |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizzy/Fainting Spells | <input type="checkbox"/> Hypoglycemia (low blood sugar) | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Kidney Problems/Recurrent UTI | <input type="checkbox"/> Tuberculosis |

Allergies:

None

Drug Allergies (Specify): _____

Other Allergies (Specify): _____

Does Patient Carry an Epi-Pen? Yes / No (circle one)

Medications: List all medication taken on a regular or frequent basis. Please include birth control pills and nonprescription drugs.

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

MENTAL HEALTH HISTORY

Have you ever received psychiatric care/counseling? Yes No Currently

Have you ever been hospitalized for psychiatric care? Yes No Currently

Have you ever been treated for an eating disorder? Yes No Currently

THE FOLLOWING MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. YOUR HEALTH CARE PROVIDER MUST UPDATE IMMUNIZATIONS TO MEET THE COLLEGE'S REQUIREMENTS.

PHYSICAL EXAM: To be completed by physician, physician's assistant or nurse practitioner no more than twelve months prior to college entrance.

Date of Exam: ___/___/___ Height: _____ Weight: _____

Examination findings (Describe fully. Use additional sheets if necessary)

| | Normal | Abnormal | Findings (please describe) |
|----------------------------|--------|----------|----------------------------|
| Head, Ears, Nose or Throat | | | |
| Eyes | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Neurologic | | | |
| Musculoskeletal | | | |
| Metabolic/Endocrine | | | |
| Skin | | | |
| Diabetes | | | |
| Psychiatric | | | |

Last Name

First Name

MI

DOB

Restrictions for Physical Activity (PE, Intramural Sports, ROTC) :

Explain: _____

Is the student now under treatment for any medical or emotional condition that requires special housing?

Yes No

Explain: _____

If Yes, the Student must complete the **Special Housing Considerations Request** form which can be found on the College's website.

Tuberculin Skin Test (PPD) Is Mandatory for all International Students.

Testing is required within 1 year prior to admission.

US Residents Testing is at the Discretion of your Clinician.

| Date Given (Mo./Day/Yr.) | Date Read (Mo./Day/Yr.) | Result (record actual mm of induration; transverse diameter; if no induration, write "0") _____ mm | Interpretation (based on mm of induration as well as risk factors) Circle one Positive/Negative |
|-----------------------------|----------------------------|---|---|
| | | | |

If greater than 10mm induration, chest x-ray required.

| Date of Chest X-ray (Mo./Day/Yr) | Result Circle One Normal / Abnormal |
|-------------------------------------|---|
| | |

** Attach a copy of chest x-ray report in English.

Document any treatment patient has received for either a positive TB skin test or active disease.

Medications received: _____

IMMUNIZATION RECORDS The following are **Required** Immunizations and Dates:

| Immunization | Date | Immunization | Date |
|---|--|---------------------------------|------|
| Tetanus (within the last 10 yrs) | | Hepatitis B #1 | |
| MMR #1 | | Hepatitis B #2 | |
| MMR #2 | | Hepatitis B #3 | |
| Polio Series | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Chickenpox Vaccine #1 | | Chickenpox Vaccine #2 | |
| OR Varicella Titre | Results _____ Date ____/____/____ | RECOMMENDED ONLY Hepatitis A | |
| Meningococcal Vaccine (or waiver signed below) | | | |

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 learning in Maryland who resides in on-campus housing shall receive the vaccination against meningococcal disease unless the individual signs a waiver to the vaccination. I choose to waive receipt of meningococcal vaccine.

Student Signature _____ Date _____
Parent/Legal Guardian Signature, if student is under 18 years of age.

_____ **Last Name**

_____ **First Name**

_____ **MI**

_____ **DOB**

Clinician Signature _____ Address _____

Print Name _____

Date _____ Phone _____

TO BE COMPLETED BY THE STUDENT:

BEFORE TURNING IN YOUR HEALTH FORM, PLEASE CHECK TO MAKE SURE THE FOLLOWING ITEMS ARE COMPLETED:

- | | |
|---|--|
| <input type="checkbox"/> General Information | <input type="checkbox"/> Person to notify in case of emergency |
| <input type="checkbox"/> Consents | <input type="checkbox"/> Copy of Insurance Card Attached |
| <input type="checkbox"/> Personal Medical History | <input type="checkbox"/> Physical Exam (within 12 months prior to admission) |
| <input type="checkbox"/> Complete Immunization Record | |

Student Signature _____ Print Name _____

Date _____