

HOPE COLLEGE HEALTH SERVICES

168 E. 13<sup>TH</sup> STREET  
 P.O. BOX 9000  
 HOLLAND, MI 49422-9000

HOPE COLLEGE  
 HEALTH HISTORY FORM

Instructions: This form is a requirement for entry to Hope College and Treatment in the Health Services.

1. Front side is to be completed and signed by the health care professional. Include TB Self-Screening tool.
  2. Backside is to be completed and signed by the Hope student. (Parent signature if under 18 years of age.)
  3. Return form by mail to Hope Health Services, at the above address, BEFORE July 1, 2009.
- **NOTE: All information is confidential and not part of academic records.** The information is only accessible to the staff of the Health & Counseling Services, unless written authorization is provided in compliance with HIPAA regulations.

Last Name (Print), First, Middle	Age _____ Birthdate (mo.dy.yr) _____ F / M
Home Street Address	Home Telephone with area code
Home City, State, Zip	Student Cell Phone number with area code

**REQUIRED FOR ENTRANCE TO HOPE COLLEGE**

<p style="text-align: center;"><b><u>Tetanus-Diphtheria-Pertussis</u></b></p> <p><input type="checkbox"/> Primary series completed?.....</p> <p><b>YES NO</b></p> <p><input type="checkbox"/> Date series completed _____</p> <hr/> <p><b>Date of last booster:</b> _____</p> <p><b>Type (Tdap or Td):</b> _____</p> <hr/> <p>For Future use: Date: _____ Type: _____</p>	<p style="text-align: center;"><b><u>Polio</u></b></p> <p><input type="checkbox"/> Primary series completed?.....</p> <p><b>YES NO</b></p> <p><input type="checkbox"/> Date series completed _____</p> <p><input type="checkbox"/> Provided within ACIP guidelines?...</p> <p><b>YES NO</b></p>	<p style="text-align: center;"><b><u>Measles-Mumps-Rubella</u></b></p> <p>(2 doses required)</p> <p><b>Dose 1</b> _____ * (age 12-15 months)</p> <p><b>Dose 2</b> _____ * (age 4-6 years)</p> <p>*or no sooner than one month apart if first dose started at an older age.</p>	<p style="text-align: center;"><b><u>Hepatitis B</u></b></p> <p>(3 doses required)</p> <p><b>Dose 1</b> _____</p> <p><b>Dose 2</b> _____</p> <p><b>Dose 3</b> _____</p> <p><input type="checkbox"/> Provided within ACIP guidelines?....</p> <p><b>YES NO</b></p> <p>Future booster(s): _____ _____ _____</p>	<p style="text-align: center;"><b><u>Chickenpox (Varicella)</u></b></p> <p><i>Must have one:</i></p> <p><input type="checkbox"/> History of disease?</p> <p><b>YES NO</b></p> <p>----- or..</p> <p><input type="checkbox"/> Immunization (2 doses required)</p> <p><b>Dose 1</b> _____</p> <p><b>Dose 2</b> _____</p> <p>----- or..</p> <p><input type="checkbox"/> Varicella antibody</p> <p><b>Test Date</b> _____ <b>Result</b> _____</p>	<p style="text-align: center;"><b><u>Tuberculosis Screening</u></b></p> <p><input type="checkbox"/> Self-screening tool reviewed?.....</p> <p><b>YES NO</b></p> <p><input type="checkbox"/> TB skin test needed?.....</p> <p><b>YES NO</b></p> <p><input type="checkbox"/> If test is indicated: Date given: _____ Date read: _____ Results in mm _____ <i>Positive Negative</i></p> <p><input type="checkbox"/> <b>Chest x-ray required if positive</b> - attach written report</p>
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<p style="text-align: center;"><b>Recommended Immunizations</b></p> <p><b><u>Meningococcal (A,C,Y,W-135)</u></b> (available at Hope College Health Center) Date provided: _____ Type provided: _____ (indicate brand name, conjugate or polysaccharide)</p> <p><b><u>Influenza Vaccine</u></b> <i>provided during college !</i> (Type/Date) _____ _____ _____</p>	<p style="text-align: center;"><b>Travel Related Immunizations</b></p> <p style="text-align: center;"><b><u>Hepatitis A</u></b></p> <p>Dose 1 _____ Dose 2 _____</p> <p style="text-align: center;"><b><u>Polio</u></b> (adult booster)</p> <p>_____</p> <p style="text-align: center;"><b><u>Typhoid vaccine</u></b> (Type/Date)</p> <p>_____</p> <p style="text-align: center;"><b><u>Yellow Fever</u></b></p> <p>_____</p>	<p style="text-align: center;"><b>Other Immunizations</b></p> <p><b><u>Gardasil</u></b></p> <p>Dose 1 _____ Dose 2 _____ Dose 3 _____</p> <p><b><u>Other</u></b> (Name/Date): _____ _____ _____</p>
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**Required Health Care Professional's Signature** (Physician, Nurse, Health Department Stamp)

Print Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

## PERSONAL & FAMILY HEALTH HISTORY

<p><b>Height:</b> _____ <b>Weight:</b> _____</p> <p><b>Medication Allergies (list):</b></p> <p><b>Medications taken regularly:</b></p> <p><b>Hospitalizations/Surgeries (with dates):</b></p> <p><b>Environmental/Food Allergies:</b></p> <p><b>Allergy to Insect bites?</b>    <b>yes</b>        <b>no</b></p>	<p style="text-align: right;">* Mark all that apply</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">Myself</th> <th style="width: 15%; text-align: center;">Family History</th> </tr> </thead> <tbody> <tr> <td><b>AutoImmune Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  Diabetes _____</td> <td></td> <td></td> </tr> <tr> <td>  Multiple Sclerosis _____</td> <td></td> <td></td> </tr> <tr> <td>  Systemic Lupus _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Blood Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  Anemia _____</td> <td></td> <td></td> </tr> <tr> <td>  Clotting Deficiency _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Cancer</b></td> <td></td> <td></td> </tr> <tr> <td>  Specify: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Cardio/Pulmonary Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  Asthma _____</td> <td></td> <td></td> </tr> <tr> <td>  Blood Clots _____</td> <td></td> <td></td> </tr> <tr> <td>  Heart Murmur _____</td> <td></td> <td></td> </tr> <tr> <td>  Heart Disease _____</td> <td></td> <td></td> </tr> <tr> <td>  High Blood Pressure _____</td> <td></td> <td></td> </tr> <tr> <td>  High Cholesterol _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Communicable Disease:</b></td> <td></td> <td></td> </tr> <tr> <td>  Chickenpox _____</td> <td></td> <td></td> </tr> <tr> <td>  Tuberculosis (active) _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Digestive Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  Crohn's Disease _____</td> <td></td> <td></td> </tr> <tr> <td>  GERD _____</td> <td></td> <td></td> </tr> <tr> <td>  Peptic Ulcer _____</td> <td></td> <td></td> </tr> <tr> <td>  Irritable Bowel Syndrome _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Eating Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  Anorexia Nervosa _____</td> <td></td> <td></td> </tr> <tr> <td>  Binge Eating _____</td> <td></td> <td></td> </tr> <tr> <td>  Bulimia _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Mental/Emotional Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  Anxiety _____</td> <td></td> <td></td> </tr> <tr> <td>  Depression _____</td> <td></td> <td></td> </tr> <tr> <td>  Suicide Attempt _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Neurological Disorders</b></td> <td></td> <td></td> </tr> <tr> <td>  ADD/ADHD _____</td> <td></td> <td></td> </tr> <tr> <td>  Cerebral Palsy _____</td> <td></td> <td></td> </tr> <tr> <td>  Migraine Headaches _____</td> <td></td> <td></td> </tr> <tr> <td>  Seizures _____</td> <td></td> <td></td> </tr> <tr> <td>  Other: _____</td> <td></td> <td></td> </tr> <tr> <td><b>Other:</b></td> <td></td> <td></td> </tr> </tbody> </table>		Myself	Family History	<b>AutoImmune Disorders</b>			Diabetes _____			Multiple Sclerosis _____			Systemic Lupus _____			Other: _____			<b>Blood Disorders</b>			Anemia _____			Clotting Deficiency _____			Other: _____			<b>Cancer</b>			Specify: _____			<b>Cardio/Pulmonary Disorders</b>			Asthma _____			Blood Clots _____			Heart Murmur _____			Heart Disease _____			High Blood Pressure _____			High Cholesterol _____			Other: _____			<b>Communicable Disease:</b>			Chickenpox _____			Tuberculosis (active) _____			Other: _____			<b>Digestive Disorders</b>			Crohn's Disease _____			GERD _____			Peptic Ulcer _____			Irritable Bowel Syndrome _____			Other: _____			<b>Eating Disorders</b>			Anorexia Nervosa _____			Binge Eating _____			Bulimia _____			Other: _____			<b>Mental/Emotional Disorders</b>			Anxiety _____			Depression _____			Suicide Attempt _____			Other: _____			<b>Neurological Disorders</b>			ADD/ADHD _____			Cerebral Palsy _____			Migraine Headaches _____			Seizures _____			Other: _____			<b>Other:</b>		
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### REQUIREMENT

*Forms postmarked after July 1, 2009 will be assessed a \$75 late fee.*

For the safety of our campus community, new students will not be allowed to move into student housing unless their immunizations are up-to-date and have been reviewed by the Hope Health Center staff.

Students are required to keep their immunization status up-to-date throughout their stay at Hope to avoid a hold on their class registration.

Students requesting an immunization waiver must do so in person at the Hope Health Center.

### STATEMENT OF AUTHORIZATION

- The information contained on this form is complete and I have not withheld any medical or mental health information. If any aspect of my health profile changes after submitting this form, I will notify the Hope Health Center of this/these changes in writing.
- I authorize the Student Health Center of Hope College to administer medical and surgical services, including immunizations and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel. I understand that the Medical Director, or designee, serves as primary physician for medical care provided by the Hope Health Center.
- I understand that I will be required to undergo medical treatment for any current or future diagnosis of Latent Tuberculosis Infection (LTBI). *Failure to do so will result in withdrawal from current coursework and living arrangements at Hope College.*

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/ Guardian if under age 18