International Students
Hope College
141 E. 12th Street
P.O. Box 9000
Holland, MI 49422-9000
Fax: 616-395-7937

Hope College
Health History Form

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

1. Front side to be completed and signed by a health care professional.
2. Backside to be completed and signed by the Hope student. (Parent signature if under 18 years of age).
3. Return form by mail or fax to Hope College at 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 and Counseling Services, unless written authorization is provided in compliance with HIPAA regulations.

Last Name (Printed), First Name, Middle	Country arriving from		
Permanent Address (Home), Street, City, State, Country	Age	Birthdate (month, day, year)	Female Male
	Home Telephone with country or area codes		

Required Immunization Series		Print dates each dose was provided in boxes below				
Diphtheria	*Combination Vaccine accepted. Minimum primary series of 3 doses and booster dose within the last 10 years.*					
Pertussis						
Tetanus						
Polio	*Minimum of 4 doses required, last dose after 4 years of age.*					
Hepatitis B	*Minimum of 3 doses required.*					
Measles (rubeola)	*Combination Vaccine accepted. Minimum of 2 doses of each component required, 2nd dose must be after 4 years of age.*					
Mumps						
Rubella						
Chickenpox (Varicella)	*Did you have this disease already?* **Yes** **No** *If no… 2 doses of Varicella vaccine required.*	Varicella Dose #1 (record below)	Vaicella Dose #2 (record below)			

Recommended Immunizations *(Available at Hope College Health Center)*	
Meningococcal (A,C,Y,W-135)	Date provided:
Influenza	*Provided at Hope College* (Date/Type) #1 ___________ _________ #2 ___________ _________ #3 ___________ _________ #4 ___________ _________
Tetanus booster	Date/Type:

Required Health Care Professional's Signature

Print Name:____ Title:_____________________________

Signature:____ Date:_____________________________

INTERNATIONAL STUDENT HEALTH HISTORY FORM (continued)

PERSONAL & FAMILY HEALTH HISTORY

Height:

Weight:

Medication Allergies (list):

Medications taken regularly:

Hospitalizations/Surgeries:

IN CASE OF EMERGENCY CONTACT

NAME:_______________________________

Relationship:____________________________
Phone # 1:______________________________
Phone # 2:______________________________

NAME:_______________________________

Relationship:____________________________
Phone # 1:______________________________
Phone # 2:______________________________

Mark all that apply:

	Myself	Family
AutoImmune Disorders:		
Diabetes		
Multiple Sclerosis		
Systemic Lupus		
Other:____________		
Blood Disorders:		
Anemia		
Clotting Deficiency		
Other:____________		
Cancer		
Specify:____________		
Cardio/Pulmonary Disorders:		
Asthma		
Blood Clots		
Heart Murmur		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Other:____________		

Mark all that apply:

	Myself	Family
Digestive Disorders:		
Crohn's Disease		
GERD		
Irritable Bowel		
Peptic Ulcer		
Other:____________		
Eating Disorder:		
Anorexia Nervosa		
Binge Eating		
Bulimia		
Other:____________		
Mental/Emotional Disorders:		
Anxiety		
Depression		
Suicide Attempt		
Other:____________		
Neurological Disorders:		
ADD/ADHD		
Cerebral Palsy		
Migraine Headaches		
Seizures		
Other:____________		

Other Immunization History - Indicate ONLY if already provided

BCG Vaccine	Hepatitis A	Typhoid	Yellow Fever	Other (Specify):
Date:__________	Date:__________ Date:__________ Date:__________	Date:__________ Date:__________ Date:__________	Date:__________ Date:__________ Date:__________	Name ______________ Date ____ __________________________ __________________________ __________________________

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 change(s) 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 Student 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

______________________________ Signuature of Parent/Guardian if under age 18