Medical & Mental Health History Form

This information will be kept confidential.

□ **Student:** Return this form to your Program Leader.

□ **Program Leader:** Take original forms with you. Leave copies with your department secretary in a sealed envelope.

Hope College Program Name:____

Faculty/Staff Leader:____

Name:____________________________ (print clearly)

Birth date:______________ (mo/day/yr)

School Address:____

School Phone:____________________ Cell Phone:____________________

Parent(s)/Guardian(s) Information:

Name:____________________

Address:____________________

____

Phone: ____________________

Name:____________________

Address:____________________

____

Phone: ____________________

Emergency Contacts:

Name:____________________

Relationship:____________________

Day Phone:____________________

Night Phone:____________________

Name:____________________

Relationship:____________________

Day Phone:____________________

Night Phone:____________________

List all allergies you have:

Medication:____________________

Food: ____________________

Environment: ____________________

Animal: ____________________

Other – specify:____________________

Bee stings? Yes No

Do you currently smoke? Yes No

Major Medical Insurance:

*Company Name:*____________________

*Phone #:*____________________

*Policy #:*____________________

*Group #:*____________________

***A copy of both the front & back of your insurance card must accompany this form.**

List any dietary restrictions:

- ☐ Vegetarian (total)
- ☐ Vegetarian (partial – specify): ____________________
- ☐ Vegan
- ☐ Lactose Intolerant
- ☐ Other (specify): ____________________

Hospitalized for: *(condition, date, location)*

____

Surgeries for: *(condition, date, location)*

____

Primary Care Physician:

*Name:*____________________

*Address:*____________________

____

*Phone:*____________________

*Fax:*____________________

Health History: *(mark all that apply)*

	Currently under treatment for	**Past** treatment for
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:		
Communicable Disease:		
Chicken pox		
Tuberculosis (active)		
Other:		
Digestive Disorders		
Crohn's Disease		
GERD		
Peptic Ulcer		
Irritable Bowel Syndrome		
Other:		
Eating Disorders		
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:		

List any special directions to be followed in case of an emergency:

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List medications you are currently taking <u>and</u> the condition(s) for which they have been prescribed:

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Date of your last Tetanus booster:

____

Date must be within the past **10 years** if travel is **within** the USA.

Date must be within the past **5 years** if travel is **outside** the USA.

I have provided the information given above in connection with my application to join a program of off-campus study (the "Program") that is being sponsored by Hope College or is being sponsored by a third party and available to students of Hope College. In signing this form below, I authorize Hope College, the Program sponsor and any of their respective agents or employees to take any and all actions that they may deem necessary or appropriate, at my expense, in order to treat and respond to any accident, illness, injury or other medial emergency that I may experience during my participation in the Program. I understand that such treatment and response may include transporting me, at my expense, to a location appropriate for medical treatment (which may, in the case if International Programs, involve transporting me back to the United States). I understand that in the event of accident, illness, injury or other medical emergency Hope College and/or the Program sponsor shall use its best efforts to promptly inform the person(s) I have listed on this form, but I agree that neither Hope College nor the Program sponsor shall have any liability for a failure to notify such person(s). I further understand and agree that all information given above shall be shared with all Program leader(s) and the Hope College Health Center Director or their representative.

Nothing in this Medical Information Form shall be construed so as to modify or abridge any acknowledgement or waiver of liability contained in the Assumption of Risk and Release, or in any other document or agreement which I have or may in the future execute in connection with my participation in the Program.

I, _______________________________, certify that I have personally completed this form. The information contained here in is complete and I have not withheld any medical or mental health information. If any aspect of my health profile changes between submitting this form and my departure for an off-campus program, I will notify the director of this/these change(s) in writing. Failure to disclose any medical or mental health information will result in my immediate return to the United States at my expense, including first class airfare if no coach class seat is immediately available.

____ _______________________
Student's Signature Date

____ _______________________
*Parent or Guardian's Signature - Required if student is under age 18 on date of signing Date