

DEFIANCE COLLEGE MEDICAL FORM

COMPLETE AND RETURN TO OFFICE OF ADMISSIONS

DATE _____ / _____ / _____

NAME _____ SOCIAL SECURITY # _____
FIRST MIDDLE LAST

HOME ADDRESS _____
STREET CITY STATE ZIP CODE

DATE OF BIRTH _____ / _____ / _____ COUNTRY OF BIRTH _____ MALE FEMALE CELL # _____

PARENT(S) OR GUARDIAN(S) _____ HOME PHONE _____
(If married, name of spouse)

EMERGENCY CONTACT _____ BUSINESS PHONE _____

FAMILY HEALTH HISTORY

CHECK EACH ITEM:	YES	NO	RELATIONSHIP	CHECK EACH ITEM:	YES	NO	RELATIONSHIP
TUBERCULOSIS <small>IF YES GIVE DETAILS BELOW YEAR EXPOSED & X-RAY</small>				STROKE			
DIABETES				ASTHMA, HAY FEVER, HIVES			
HIGH BLOOD PRESSURE				EPILEPSY OR CONVULSIONS			
HEART TROUBLE				NERVOUS OR MENTAL DISEASE			
MOTHER LIVING?				CANCER			
FATHER LIVING?			NO. OF BROTHERS LIVING _____ NO. OF SISTERS LIVING _____ IF DEAD GIVE RELATIONSHIP AND CAUSE OF DEATH				
OTHER							

PERSONAL HEALTH HISTORY

IF YOU HAVE EVER HAD OR PRESENTLY HAVE ANY OF THE FOLLOWING, PLEASE CHECK:
(IN LINES OF MULTIPLE STATEMENTS: CROSS OUT THE INAPPLICABLE WORDS.)
 EXPLAIN ALL POSITIVE ANSWERS BELOW.

INFECTIOUS DISEASE	YES	NO	HEART & LUNGS	YES	NO	GASTRO-INTESTINAL	YES	NO	NEUROLOGICAL	YES	NO
MONONUCLEOSIS			HEART TROUBLE / MURMER			ULCERS OR ULCERATIVE COLITIS			HEADACHES OR MIGRAINES		
TUBERCULOSIS			HIGH OR LOW BLOOD PRESSURE			STOMACH OR INTESTINAL TROUBLE			PSYCHIATRIC PROBLEMS		
EYES, EARS, NOSE			RHEUMATIC FEVER / SCARLET FEVER			HEPATITIS OR LIVER DISEASE			MOTION SICKNESS		
WEAR GLASSES OR CONTACTS			SHORTNESS OF BREATH			APPENDICITIS			DIZZY OR FAINTING SPELLS		
BLURRED VISION			PALPITATIONS			RUPTURE OR HERNIA			EPILEPSY OR CONVULSIONS		
HAY FEVER OR ALLERGIES			EXERCISE INDUCED ASTHMA			EATING DISORDERS			NERVOUS TROUBLE OF ANY SORT		
COMMUNICABLE DISEASE			ASTHMA			GENITAL-URINARY			DEPRESSION		
MEASLES, MUMPS			CHRONIC COUGH			KIDNEY STONE			HEAD INJURY OR CONCUSSION		
CHICKENPOX			METABOLIC			BLADDER/ KIDNEY TROUBLE			OTHER		
LOCK JAW OR DIPHTHERIA			DIABETES			HEMATOLOGIC			BONE OR JOINT PROBLEMS		
WHOOPING COUGH			THYROID DISEASE			ANEMIA			SMOKE / ALCOHOL USE OR ABUSE		
CHRONIC OR FREQUENT COLDS			HYPOGLYCEMIA			BLOOD DISORDER			SKIN DISEASES, RASH, OR BOILS		
SINUSITIS			COLD SORES OR HERPES			MENSTRUATION PROBLEMS			LOSS OF ANY BODY PART		

IF YES ABOVE, OR ANY OTHER DISEASE GIVE DETAILS: _____

HAS YOUR HEALTH BEEN: GOOD _____ FAIR _____ POOR _____ EXPLAIN _____

CHECK EACH ITEM	HAVE YOU:	YES	NO	IF YES, EXPLAIN BELOW. PLEASE NUMBER ANSWERS.
1. ANY PHYSICAL LIMITATIONS?				
2. EVER BEEN A PATIENT IN A HOSPITAL?				
3. ANY SURGICAL PROCEDURE?				
WHEN YOU ENTER COLLEGE WILL YOU NEED				
4. TO TAKE ALLERGY SHOTS?				
5. TO BE SEEN BY A DOCTOR REGULARLY?				
6. NEED SPECIAL HOUSING CONSIDERATIONS?				
7. TO BE EXCUSED FROM PHYSICAL EDUCATION?				
8. PSYCHIATRIC CONSULTATION OR THERAPY?				
9. CARE FOR ANY EXISTING INJURY OR ILLNESS?				
10. TO TAKE MEDICATION REGULARLY, LIST THEM				
				STUDENTS SIGNATURE _____ DATE _____

MEDICAL HISTORY FORM

This Health Record is a requirement by law and for admission to Defiance College. It is DC policy to have in our medical files documented proof of immunization and a personal health history on each incoming student. This is for your protection as well as the other students and the community. It is important to the Defiance College Health Center to provide you with the best medical care possible while you are a resident or commuter student.

The easiest method of obtaining your immunization record is from your high school, your medical records, or your County Health Department. If possible, obtain a copy and attach it to this form. If your health record and/or immunization record is not complete or up-to-date by registration, we will require that you receive the needed immunizations. All information is kept confidential and can be released only upon your written consent.

Mail completed forms to **Office of Admissions, Defiance College, 701 North Clinton Street, Defiance, Ohio 43512**, or use the business reply envelope provided.

We appreciate your cooperation in regards to your health needs.
Defiance College Health Center

<p>Office use only:</p> <p>YEAR IN COLLEGE:</p> <p><input type="checkbox"/> Freshman</p> <p><input type="checkbox"/> Sophomore</p> <p><input type="checkbox"/> Junior</p> <p><input type="checkbox"/> Senior</p> <p>STARTING SEMESTER</p> <p><input type="checkbox"/> Fall 20____</p> <p><input type="checkbox"/> Spring 20____</p> <p><input type="checkbox"/> Summer 20____</p> <p>Medical Record received in admissions:</p> <p>_____</p> <p>Date _____</p>	<p>Student Name _____ Date of Birth ____/____/____</p> <p>Height _____ Weight _____ Age _____</p> <p>Do you have any signs of emotional instability? YES _____ NO _____</p> <p>Do you have any drug allergies? YES _____ NO _____</p> <p>If so, explain reaction _____</p> <p>_____</p> <p>Are you on any medications? YES _____ NO _____</p> <p>If so, what _____</p> <p>_____</p> <p>Explain all yes answers above and/or use for additional comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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HEPATITIS B AND MENINGITIS VACCINES
We are required by Ohio law to document that all residential students receive or refuse the Hepatitis B and Meningitis vaccines.

Please complete with dates when you received the Hepatitis B and Meningitis vaccines:

Hepatitis B #1 _____ Meningitis _____
 #2 _____
 #3 _____

REFUSAL SECTION

Go to www.defiance.edu for more information.

____ I have read the information about **Meningitis** and am aware of the consequences from this disease. I **wish not** to receive this vaccination at this time.

____ I have read the information about **Hepatitis B** and am aware of the consequences from this disease. I **wish not** to receive this vaccination at this time.

Defiance College Office of Admissions
 701 North Clinton Street
 Defiance, Ohio 45312
 Phone: 419-783-2359 Fax: 419-783-2468

REQUIRED FOR ADMISSION:

TUBERCULIN TEST: WITHIN 1 YEAR Date _____

IF POSITIVE, NEEDS CHEST X-RAY _____ NEG. _____ POS. _____

IMMUNIZATION HISTORY

TETANUS – DIPHTHERIA – PERTUSSIS Date _____

POLIO Date _____ **CHICKEN POX** Date _____

MMR #1 Date _____ **MMR #2** Date _____

Hepatitis A: Date #1 _____ Date #2 _____
 Not required for admission, only if received:

I, the undersigned student (if 18 years of age) or parent (if student is under age 18), have read and understand the information provided to me about these immunizations. I understand the benefits and risks of being vaccinated against these diseases. The information regarding my (my student's) vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133 (B).

STUDENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE: _____ DATE _____
 (REQUIRED IF STUDENT IS UNDER THE AGE OF 18)