

CALVIN COLLEGE HEALTH SERVICES
HEALTH HISTORY

All new students are required to complete and return this form.
 It may be submitted online, by mail, or by fax. See contact information at page bottom.

GENERAL INFORMATION:

Last Name (Print), First, Middle	Date of Birth	Calvin ID #
Home Street Address	Student Status: F S J S Grad.	Year Entering Calvin
Home City, State, Country, Zip/Postal Code	Sex: M F	Marital Status: S M D W
E-mail Address and Cell Phone	Height	Weight

PARENT or GUARDIAN CONTACT INFORMATION:

Last Name (Print), First, Middle	Relationship	Home Phone
Home Street Address, City, State, Country, Zip/Postal Code		Work Phone
Alternate Address	E-mail Address	Cell Phone

ALTERNATIVE EMERGENCY CONTACT INFORMATION (local or nearest Calvin):

Last Name (Print), First, Middle	Relationship	Home Phone
Home Street Address, City, State, Country, Zip/Postal Code		Work Phone
Alternate Address	E-mail Address	Cell Phone

PERSONAL HEALTH HISTORY: Please answer the following and provide pertinent information:

- I have been treated by a health care provider or therapist for a health concern. Please list:
- I am taking prescription medications regularly. Please list:
- Hospitalizations/Surgeries: Please list, with dates:
- Food or drug allergies: Please list:
- I have received services for a disability. Please list:

Select any of the physical or mental problems you currently have or have ever had. Please enter the dates you had them.

<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	Allergy injections	<input type="checkbox"/>	Hepatitis/ Liver Disease
<input type="checkbox"/>	Anxiety and/or depression	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Kidney/Urinary Problems
<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Neurological Problem or Seizures
<input type="checkbox"/>	Bone/Joint Problems	<input type="checkbox"/>	Skin Problem
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Sleep Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	Eating Disorder/Low Weight	<input type="checkbox"/>	Vision(other than corrective lenses)/Hearing
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Other/Not Listed

The deadline for this form is July 1; for late enrollments, the deadline is September 1.