Health Services

RIPON COLLEGE

TO THE STUDENT ENTERING RIPON COLLEGE:

During your attendance at Ripon College you will have available to you facilities and services outlined in the Ripon College *Catalog* and *Handbook*, in the section entitled "Health Services." In order to provide properly for your health needs, the Health Services must have the information requested on this form as the basis for the health record which will be maintained for you as a Ripon student. You will be eligible for routine care at the Ripon College Health Services when this information is on file and registration has been completed.

Please note that this form is in two parts. Part I is to be filled out by the student and reviewed by the physician. Part II is to be filled out by the examining physician. Complete the form and return it in the enclosed self-addressed envelope at least **two weeks prior to the first day of class** at Ripon College. Please print in ink or type the information requested.

Because you have already been accepted for admission, the information you and your physician supply will not affect your status at Ripon and will not be released to anyone except by your written authorization.

Office of Admission
Ripon College
300 Seward Street
Post Office Box 248
Ripon, WI 54971-0248
1-800-947-4766

Part I: Health History

This form is confidential. Please answer all questions.

Print Name ____ Date filled out ______________
Last First Middle

Home Address ____
Street City State Zip

Home Phone ______________ Date of Birth ______________ Age ________ Sex ❑ M ❑ F

Social Security # ______________________________

Notify in Emergency ______________________________ Phones: Home ______________
Name/Relationship Other ______________

Do you have health insurance? ❑ No ❑ Yes Insurance Company ______________________

Policy Owner ______________________ ID Number ______________ Group Number ______________

Please send this form, along with a copy of the front and back of the parent's health insurance card, to the Office of Admission. (Use enclosed self-addressed envelope.)

Personal Medical History

Have you had any serious injury, operation, illness or disease? ❑ No ❑ Yes

If yes, explain and include dates: ____

Have you received out-patient treatment or been hospitalized for an emotional health issue? ❑ No ❑ Yes

If yes, explain and include dates: ____

Are you currently taking any prescribed or over-the-counter medications or treatments? ❑ No ❑ Yes

If yes, please note medication and dosages: ____

Do you have reactions to any medicine or antibiotics? ❑ No ❑ Yes

List type of reaction and what causes it: ____

Do you have any allergies? Check all which apply and specify. ❑ No ❑ Yes ❑ Food ❑ Medicines ❑ Insects ❑ Other

Specify: ____

Do you take allergy shots? ______________ Allergist ______________________________

Address ______________________________
Street City State Zip

Phone ______________________________

Please provide information regarding your personal health care provider.

Name ______________________________ Telephone Number ______________

Address ______________________________ Length of Time Provider Has Known You ______________
Street City State Zip

Family Medical History

Have you or your immediate family (parents, sister, brother, children) had the following?

	NO	YES		NO	YES
Allergy	❑	❑	Hypertension	❑	❑
Cancer	❑	❑	Mental Illness	❑	❑
Diabetes	❑	❑	Migraine Headaches	❑	❑
Heart Disease	❑	❑	Seizure Disorder	❑	❑
High Cholesterol	❑	❑	Tuberculosis	❑	❑

Explain all yes answers: ____

Immunization Record

INDICATE YOUR IMMUNITY BY CHECKING THE APPROPRIATE BOXES AND THEN SPECIFYING RELEVANT DATES BELOW

(1) Tetanus/Diphtheria **Date**

❑ PRIMARY SERIES OF DPT COMPLETED ________

❑ TETANUS BOOSTER (Within last 10 years) ________

(2) M.M.R. (Measles, Mumps, Rubella)

If you have had MMR vaccine ________

❑ DOSE 1 (After 12 mos. and before 5 years old) ________

❑ DOSE 2 (5 yrs. old or after) ________

(3) Varicella (Chicken Pox)

❑ HAD DISEASE ________

❑ VACCINE SERIES DATES ________, ________

(4) Polio **Date**

❑ COMPLETED PRIMARY VACCINATION SERIES ________

TYPE OF VACCINE:

❑ ORAL ❑ INACTIVATED

❑ BOOSTER ________

(5) Hepatitis B

❑ HAD DISEASE; CONFIRMED BY OFFICE RECORD ________

❑ VACCINE SERIES DATES ________, ________, ________

(6) Meningitis

❑ VACCINE ________

Tuberculosis Test

(Indicate date of most recent test and result)

Date ____________________ PPD ____________________ Chest X-Ray ____________________

Medical Treatment/Medical Permission

Medical care provided at Health Services is without charge and includes nursing evaluation, available medications, available laboratory tests, health education materials and information. Permission is hereby granted to attending medical personnel to provide needed medical treatment, medication and immunizations for

Date ____________ Signature ____

Parent/Guardian Signature if Student is a Minor ____

[Student health files will be maintained at Health Services for a period of seven years after date of last visit.]

Part II: Physician's Report of Health Evaluation

TO THE EXAMINING PHYSICIAN: Please review the student's report and complete this physician's form, with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by Health Services. It will not be released to anyone without the student's consent. This form should be given to the student, who will return it to the college.

Name ____ Sex ❑ M ❑ F
Last First Middle

BP ____________________ Height ____________________ Weight ____________________

Vision: Without Correction (R) 20/__________ (L) 20/__________
With Correction (R) 20/__________ (L) 20/__________

Urinalysis: Normal ____________________ Abnormal ____________________

Tuberculosis skin test: Type ______________ Date Applied ________ Result ________ HCT or Hgh ________

Are there any significant problems not covered on this form? ________________________________

Do you suggest restrictions or limitations? ________________________________

Are there any abnormalities of the following systems? Describe fully.

		YES	NO	
1.	Head, ears, nose or throat	❑	❑	________
2.	Respiratory	❑	❑	________
3.	Cardiovascular	❑	❑	________
4.	Gastrointestinal	❑	❑	________
5.	Hernia	❑	❑	________
6.	Eyes	❑	❑	________
7.	Genitourinary	❑	❑	________
8.	Musculoskeletal	❑	❑	________
9.	Metabolic/Endocrine	❑	❑	________
10.	Neuropsychiatric	❑	❑	________
11.	Skin	❑	❑	________

Physician's Name ________________________________
Please Print or Type

Address ________________________________

Phone ________________________________

Date ________________________________

Physician's Signature ________________________________