

Marietta College Student Health Center
Medical Health Form
215 5th Street
Marietta, OH 45750

All students need to complete and return the Health Form by August 1.

Personal Information

Name _____ SS# _____
Last First MI

Address _____
Street City State Zip Code

Date of Birth ____/____/____ Age ____ Male ____ Female ____ Home Phone _____

Cell Phone _____

Emergency Phone Numbers- including cell phone numbers

Parent/Guardian/Spouse _____
(circle one)

If parent/guardian unavailable: Name _____ Phone # _____ Relationship _____

Insurance Information

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR FAMILY INSURANCE CARD.

Personal Health History

1. List any pertinent medical conditions or physical limitations _____
2. Allergies? Yes ____ No ____ Please list all allergies: _____
3. List all medications you are taking _____
4. **Yes or NO-** Have you ever had? Rheumatic fever ____ Heart trouble ____ Cancer ____
Diabetes ____ History of Seizure Disorder _____
5. List any operations and injuries (include dates) _____
6. Additional information you would like us to know concerning your health _____

Family Health History

List any significant family health history (parents, grandparents, siblings) _____

**If deceased, please list cause _____

Authorization for Medical Procedures

I authorize and request Marietta Memorial Hospital to administer out-patient medical, surgical, services and immunizations and to perform emergency procedures, as necessary, or to refer to duly licensed medical personnel when indicated including transfer to outside hospitals.

Also, I authorize any physician, practitioner, clinic or hospital to furnish to Marietta Memorial Hospital all information concerning my case history and the treatment, examinations or hospitalization which I received in the past, including copies of hospital and medical records.

In case of illness or accident deemed serious by the Director of Health Service or the College physician(s), I authorize said persons to notify the parent or guardian named on this form, and the Dean of Students Office if I am unable to do so. I hereby authorize the College physician(s) or Director of Health Services operating under the physician's protocol to hospitalize me in case of emergency.

Signature of Student

Date

Signature of Parent or Guardian (if less than 18)

Immunization Record-(Immunizations/Vaccines Required for Enrollment)

Vaccine	Date of dose 1	Date of dose 2	Date of dose 3	Date of dose 4
Tetanus-Diphtheria-Pertussis: within the last ten years	___/___/___ M D Year	___/___/___ M D Year	___/___/___ M D Year	___/___/___ M D Year
Measles, Mumps & Rubella: Two Immunizations	___/___/___ M D Year	___/___/___ M D Year		
Polio: Completed primary series of polio immunizations	___/___/___ M D Year	___/___/___ M D Year	___/___/___ M D Year	___/___/___ M D Year Last Booster
Meningococcal Vaccine : 1 dose	___/___/___ M D Year			
Hepatitis B vaccine: 3 doses	___/___/___ M D Year	___/___/___ M D Year	___/___/___ M D Year	(or) Result: __reactive __non-reactive
Varicella (Chicken Pox) History of disease: __Yes __No	___/___/___ M D Year	___/___/___ M D Year		

Tuberculosis Screening Questionnaire

All Marietta College students are required to provide information about overseas travel and possible exposure to tuberculosis (TB) prior to the start of classes. If you have been overseas, you should be tested for TB within 8-10 weeks after returning to the United States.

1. Have you ever had a positive TB test? _____ Yes _____ No

2. Have you lived or traveled to a country OTHER than those listed below? _____ Yes _____ No

3. If so, give name of country _____ Dates of travel _____

American Samoa Australia Belgium Canada Denmark Finland Germany Greece
Iceland Jamaica Liechtenstein Malta Monaco Norway Netherlands San Marino
Switzerland St. Kitts & Nevis St. Lucia UK US Virgin Island New Zealand

4. Have you ever been vaccinated with BCG for TB? _____ Yes _____ No

5. Have you had any of the following symptoms?

3 weeks of unexplained cough or bloody sputum? _____ Yes _____ No

Unexplained night sweats, weight loss, or fever? _____ Yes _____ No

6. Do you have any of the following risk factors to TB infection?

Cancer or long term immunosuppressive therapy or steroids? _____ Yes _____ No

Use of Illegal drugs? _____ Yes _____ No

Close contact with an active TB patient? _____ Yes _____ No

HIV infection or AIDS? _____ Yes _____ No

Recent resident or employee of correctional facility, nursing home,
homeless shelter, or health care setting? _____ Yes _____ No

If you answered yes to any of the above questions, you will need to provide a record of a TB skin test administered in the U.S. to Marietta College's Health Service Center. Previous BCG vaccination does not exempt you from TB testing.

Physician's signature _____ Date _____

Please print stamp or type name _____

Address _____