

RETURN BY: JULY 15

Registration procedures will be delayed and campus activities forbidden if this form is not received by July 15.

HEALTH FORM

Garrison-Foster Health Center
Colby College
4460 Mayflower Hill Drive
Waterville, ME 04901-8844
fax: (207) 872-3465
tel: (207) 872-3395

Student Complete This Side - Answer Each Question

Information on this required medical history and physical examination form will not effect your student status as it is used solely to assist the Health Center in providing health care. Information from this form or your health care record while you are at Colby will not be released, even to parents, without your consent.

PROPER MEDICAL CARE CANNOT BE ADMINISTERED WITHOUT THE INFORMATION ON THIS FORM.

Last Name First Name Middle Name Sex (M/F) Date of Birth (M.D.Yr)

Home Address (Number and Street) City or Town State Zip Country

Name, Relationship, and Address of Parent or Guardian Area Code + Home Telephone No.

Name of Additional Contact Person (if we are unable to reach person at tel # above) Relationship Area Code + Telephone No.

FAMILY HISTORY

	Age	Occupation	Medical problems?/Cause of death	Student's Siblings	Their ages	Medical problems
Father				# Sisters		
Mother				# Brothers		

Do you smoke? Do you chew tobacco?
 Have you ever been ill or injured from alcohol use? Do you have a parent with an alcohol problem?
 Do you always wear a seat belt when in an auto?
 Do you wear glasses? contacts?
 Have you ever lived outside the US for 6+ months? What country?
 Has your physical activity been restricted during the past five years? No Yes (Give reasons and duration in remarks section)

REMARKS SECTION

Please list here any physical or psychological problems which are current or on-going.

PERMISSION - MUST SIGN BELOW:

Permission for release of medical information:
 I authorize release of relevant medical information to my insurance company for the purpose of reimbursement.

Permission to contact home provider:
 I authorize Garrison-Foster Health Center to contact provider whose name appears on back of this form about any information missing from medical examination or immunization record.

Permission for medical care:
 I authorize Garrison-Foster Health Center to provide medical services, or when circumstances require immediate action, to proceed according to standard medical practice in the treatment of:(student's name) _____

Student signature: _____ Date: _____

If student is under 18 years of age:

Parent/guardian signature: _____ Relationship: _____ Date: _____

Physician/Health Care Provider Complete This Side

MEDICAL HISTORY Indicate at what age student had/has any of the following and note if problem is resolved "R" or chronic "C" :

ILLNESS	NO	YES (AGE)	ILLNESS	NO	YES (AGE)	ILLNESS	NO	YES (AGE)
Head injury with unconsciousness			Tuberculosis			Fainting after exertion		
			Stomach problem			Tumor, cancer, cyst		
Migraine headache			Intestinal problem			Diabetes		
Seizure disorder/epilepsy			Rheumatic fever			Alcohol or drug problem		
Sinusitis			Heart murmur			Eating disorder		
Asthma			High blood pressure			Depression		
Surgery/Hospitalizations:			Menstrual problems			Orthopedic problems		
			Anemia			Other:		
			Chest pain with exercise					

PRESCRIPTION MEDICATIONS? NO YES (LIST ANY REGULAR MEDS, WHICH STUDENT WILL BRING TO COLBY)

ALLERGIES? NO YES (LIST BELOW)
 Medication allergies:
 Foods allergies:
 Environmental allergies:

Blood Pressure:

Pulse:

MEDICAL EXAMINATION

Height:

Weight:

Build: Slender Medium Heavy Obese

Normal	Abnormal	Check each item in proper column	NOTE: Give details of each abnormality
		Head, face, scalp and skull	
		Nose and sinuses	
		Mouth and throat (include teeth & gingiva)	
		Neck (include thyroid)	
		Ears	
		Eyes	
		Lungs	
		Heart	
		Abdomen (include hernia)	
		G-U System	
		Extremities	
		Musculo-skeletal	
		Skin and lymph nodes	
		Neurological/Psychological	

INTERCOLLEGIATE SPORTS PERMISSION

This section must be answered for all students, whether or not they intend to participate in a sport while at Colby.

Does student have clearance to participate in sports activities or team sports?

- Yes**, full participation
- Partial participation** List Restrictions _____
- No** Reason _____

Is any follow-up by a College practitioner indicated? _____

Physician's Signature _____

Date of exam _____

Printed Name _____

Address _____

Tel: Area Code ____ Number _____

Enclose Health Form and Immunization Record in the business size envelope addressed to COOT and mail with COOT materials; if no COOT, may mail directly to Health Center by July 15. History and Physical Exam information is confidential and will be reviewed by Health Center Staff.