SIENA HEIGHTS UNIVERSITY
Adrian, Michigan

Health History Form

(Required before moving into Residence Halls)

The overall health of our students is of the utmost importance. Your health history is vital and will aid in providing health care while you are enrolled at Siena Heights University. Carefully complete this **Health History Form**, and return it to us as soon as possible. If you are being treated for any health condition, please ask that a summary be sent to us for inclusion in your health record. All information will be kept confidential and used only to provide safe and complete care for you as a student. No medical information can be released to anyone, including your parents, without your written permission.

Full Legal Name_____ Date of Birth_____ Student ID #_____

Street Address_____ City_____

State_____ Zip Code_____ Country_____

Student Cell Phone #_____ Home Phone #_____

❑ Campus Resident ❑ Commuter ❑ Male ❑ Female

Emergency Contact Information

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Insurance Information

Insurance Company Name_____ Subscriber's Name_____ Group #_____ Policy #_____

Family Physician

Name_____ Phone #_____

Street Address_____ City_____ State_____ Zip_____

Immunizations

Immunizations provide protection against life-threatening diseases. We advise you to contact your provider to discuss immunization status and obtain any needed immunizations prior to arrival on campus. The following immunizations are critical due to the age of your student and/or the ease of transmission of the disease on campuses:

- Meningococcal ACWY
- Meningococcal Serogroup B
- Tdap (tetanus, diphtheria, pertussis) one dose after 11 years of age to protect against "whooping cough"
- HPV (Human papillloma virus)
- MMR (measels/mumps/rubella)
- Hepatitis A
- Hepatitis B
- Varicella

Please attach your record of immunizations to this form.

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Please circle if you have had, or currently have, any of the following, and provide approximate dates below.

Asthma	Bronchitis/Pneumonia	Frequent Colds
Alcoholism or Chemical Dependency	Headaches/Chronic Migraines	Heart Disease/Heart Murmur
Anemia or Bleeding Disorder	Dental Problems	Lung Disease
High Blood Pressure	Obesity	Bone or Joint Disease
Hepatitis	Cancer	Rheumatic Fever
Chickenpox	Diabetes or Hypoglycemia	Thyroid Disease
Kidney Disease	Ruptured or Enlarged Spleen	Ruptured Hernia
Head Injury/Concussion	Meningitis	Marfan Syndrome
Mononucleosis	Skin Disease	Epilepsy/Seizure Disorder
Psychiatric Treatment	Eating Disorder	Suicide Attempts
Depression	Anxiety	Pregnancy
Tuberculosis	Seasonal Allergies/Hay Fever	ADD/ADHD
Severe Acne	Fainting	Stomach Problems
Recurrent STD's	Genital Herpes	Urinary Tract Infection
Other Conditions:		

Please explain, and provide dates for, any conditions circled above:_____

_____

Current Medications:_____

Hospitalizations/Surgeries:_____

Allergies:_____

Family History

	Age	State of Health	Occupation	(If deceased) Age at Death	(If deceased) Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

I certify that the above information is complete and accurate. In an emergency, I give permission to the University to contact my parent(s) or guardian(s) in order to provide them with information regarding my medical condition.

Student Signature_____Date_____

PARENT OR GUARDIAN: I hereby give my permission for such necessary and emergency care to be given to my son/daughter at an approved medical facility (to be signed by parent or guardian for all applicants under 18 years of age).

Signature of Parent or Guardian_____ Date_____