



Part I
Mitchell College Health Services Student Health Form
Authorization to Treat & Personal History

Student Information

Student Name: Birth Date: Sex (assigned at birth):

Preferred Name: Preferred Pronouns:

Address:

Cell Phone Number (in order to contact you ON campus):

Emergency Contacts

1. Name Relationship Telephone Number

2. Name Relationship Telephone Number

Health Insurance- Fill in below OR attach copy of insurance card.

Students are required to have medical coverage. Without identified insurance coverage you will be automatically enrolled and billed for the College Student Health Insurance Plan. For information on the college insurance plan, or to waive coverage, please visit: www.gallagherstudent.com or contact the admissions office for additional information.

Table with 4 columns: Name of Insurance Company, Member ID Number, Group Number, Policy Holder Name and DOB

Student Authorization for Treatment

I, hereby authorize Mitchell College Health and Wellness Services to provide medical treatment and services as they deem appropriate. If I require services that incur a charge, I shall assume full financial responsibility. In the event of serious illness or injury, parents or guardians will be notified at the discretion of the professional staff. I understand that confidentiality may be broken if my life or that of another person is in danger. This authorization will remain in effect as long as I am a student at Mitchell College.

Student Signature Date

Signature of Parent or Guardian (for students under 18 years of age) Date

Last Name	First Name	Date of Birth																								
<b>MEDICAL HISTORY to be completed by STUDENT</b>																										
Allergies: List and explain reaction	Do you carry an EpiPen? <input type="checkbox"/> YES <input type="checkbox"/> NO Are any of these allergies life threatening? <input type="checkbox"/> YES <input type="checkbox"/> NO																									
Medications: List all prescription and over the counter medications, dose, and reason for taking medication																										
<p><b>Personal Medical History: Have you ever been diagnosed with the following conditions? Circle all that apply. Please provide additional detail in space below if currently under care of provider for this condition.</b></p> <table style="width: 100%; border: none;"> <tr> <td>Anemia</td> <td>Asthma</td> <td>Bleeding Disorder</td> <td>Cancer</td> </tr> <tr> <td>Cardiac Conditions</td> <td>Concussion</td> <td>Dental Problems</td> <td>Diabetes</td> </tr> <tr> <td>Eye Conditions</td> <td>GI Conditions/IBS</td> <td>GYN Conditions</td> <td>Headache/Migraine</td> </tr> <tr> <td>Hepatitis B/C</td> <td>Hypertension</td> <td>HIV/AIDS</td> <td>Mononucleosis</td> </tr> <tr> <td>Seizures/Epilepsy</td> <td>Sickle Cell Disease</td> <td>Sleep Disorder</td> <td>Stroke</td> </tr> <tr> <td>Thyroid Disorder</td> <td>Tuberculosis</td> <td>Other-Explain Below</td> <td></td> </tr> </table> <p>Have you ever had a concussion? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, how many?</i> _____</p> <p>Have limits ever been placed on you as to the amount and nature of physical exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>If yes, please explain:</i> _____</p> <p style="font-size: small;">*Please note, if history of seizures/epilepsy, we strongly recommend a seizure action plan to be completed by a medical provider regardless of how "stable" medical condition has been over the years. This should be included in Part 2 of the physical form.</p>			Anemia	Asthma	Bleeding Disorder	Cancer	Cardiac Conditions	Concussion	Dental Problems	Diabetes	Eye Conditions	GI Conditions/IBS	GYN Conditions	Headache/Migraine	Hepatitis B/C	Hypertension	HIV/AIDS	Mononucleosis	Seizures/Epilepsy	Sickle Cell Disease	Sleep Disorder	Stroke	Thyroid Disorder	Tuberculosis	Other-Explain Below	
Anemia	Asthma	Bleeding Disorder	Cancer																							
Cardiac Conditions	Concussion	Dental Problems	Diabetes																							
Eye Conditions	GI Conditions/IBS	GYN Conditions	Headache/Migraine																							
Hepatitis B/C	Hypertension	HIV/AIDS	Mononucleosis																							
Seizures/Epilepsy	Sickle Cell Disease	Sleep Disorder	Stroke																							
Thyroid Disorder	Tuberculosis	Other-Explain Below																								
<p><b>Family Medical History: Circle all that apply.</b></p> <table style="width: 100%; border: none;"> <tr> <td>Depression</td> <td>Heart Attack</td> <td>High Blood Pressure</td> <td>Heart Disease</td> <td>Stroke</td> <td>Medical History Unknown</td> </tr> <tr> <td>Diabetes</td> <td>Cancer</td> <td>Asthma/Lung Disease</td> <td>Blood Clot</td> <td>Sudden death before age 50</td> <td></td> </tr> </table>			Depression	Heart Attack	High Blood Pressure	Heart Disease	Stroke	Medical History Unknown	Diabetes	Cancer	Asthma/Lung Disease	Blood Clot	Sudden death before age 50													
Depression	Heart Attack	High Blood Pressure	Heart Disease	Stroke	Medical History Unknown																					
Diabetes	Cancer	Asthma/Lung Disease	Blood Clot	Sudden death before age 50																						
List any additional information that Health Services should know about your physical health and medical history.																										

Last Name	First Name	Date of Birth
-----------	------------	---------------

All information disclosed will be kept confidential and shared with appropriate college personnel on a need-to-know basis

**MENTAL HEALTH HISTORY to be completed by STUDENT**

**Mental health issues can influence adjustment to and academic success in college. This voluntary section is designed to inform Health Services of existing mental health issues and prior treatment.**

**Have you had or experienced any of the following:** (If yes, explain in space below or add additional pages if needed)

- |   |  |
|---|--|
| Depression <input type="checkbox"/> YES <input type="checkbox"/> No                               | Disordered eating <input type="checkbox"/> YES <input type="checkbox"/> NO               |
| Anxiety <input type="checkbox"/> YES <input type="checkbox"/> NO                                  | Bipolar disorder <input type="checkbox"/> YES <input type="checkbox"/> NO                |
| Anger management issues <input type="checkbox"/> YES <input type="checkbox"/> NO                  | Attention Problems (ADD, AD/HD) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Obsessive-compulsive disorder <input type="checkbox"/> YES <input type="checkbox"/> NO            | Post-traumatic stress disorder <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| Gambling disorder <input type="checkbox"/> YES <input type="checkbox"/> NO                        | Other (please specify) _____   |
| Suicidal Ideations/Prior Suicide Attempt <input type="checkbox"/> YES <input type="checkbox"/> NO | Self-harming behavior(s) <input type="checkbox"/> YES <input type="checkbox"/> NO        |

Alcohol or substance abuse or dependence  YES  NO

How much alcohol do you consume in one week? \_\_\_\_\_

Do you vape, smoke, or use tobacco products?  YES  NO If yes, how often? \_\_\_\_\_

-----

-----

-----

-----

-----

**Mental Health Treatment History:**

Have you ever received any treatment for any mental health or psychological concern?  YES  NO

Have you ever been hospitalized for a psychiatric disorder?  YES  NO If yes, when \_\_\_\_\_

Are you currently participating in outpatient therapy?  YES  NO

Do you intend to continue meeting with your at-home therapist while attending college?  YES  NO

Do you need assistance finding off-campus psychological or psychiatric services?  YES  NO

Are you currently taking medication for any of the above?  YES  NO (If yes, specify medications)

\_\_\_\_\_

Do you intend to continue taking medication during college?  YES  NO

Do you need assistance with transferring prescriptions or finding medication delivery to campus?  YES  NO

I decline to report any mental health history  YES  NO

**Student Acknowledgment:**

**I have read and completed all aspects of the health form and provided accurate information about my medical and mental health history.**

---

Student Signature \_\_\_\_\_ Date \_\_\_\_\_