Spring Arbor University
Holton Health and Wellness Services
106 E. Main St.
Spring Arbor, Michigan 49283
Phone (517) 750.6352 Fax (833) 561.2587
holtonhealth@arbor.edu

The following health history is confidential and does not affect your admission status. This information is requested to determine if you have any health conditions that may require special assistance from the University. This information will be used to help us provide continuity of care for you. This information will not be released without your written permission except in an emergency situation, by parental consent if under age 18. Please attach additional sheets for any items that require additional explanation.

SECTION 1: REPORT OF MEDICAL HISTORY — To be completed by student

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH**

PERMANENT ADDRESS **CITY** **STATE** **ZIP CODE** **COUNTRY** **STUDENT CELL #**

GENDER: __ M __ F MARITAL STATUS: ___S ___M

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE

NAME AND ADDRESS OF HEALTH INSURANCE CO.____

POLICY HOLDER NAME_______________________POLICY/ID/SUBSCRIBER# _______________GROUP# ________

POLICY HOLDER DATE OF BIRTH________________RELATIONSHIP TO STUDENT__________________________

INSURED ID# (if different than subscriber ID#):____

PLEASE ATTACH ***and send to holtonhealth@arbor.edu***

A SCANNED OFFICIAL DOCUMENTATION OF YOUR CHILDHOOD AND ADULT IMMUNIZATIONS (SAU Requirements: Hepatitis B Series(3 vaccines), Tetanus, Diphtheria, Pertussis(4 vaccines & booster(Td or Tdap within the last 10 years, Measles, Mumps, & Rubella (MMR) Series(2), Polio Series (4 vaccines OR 3 if #3 administered at or after age 4), Varicella Series (2 vaccines OR documented date of chicken pox illness). Meningitis-recommended, not required.)

A SCANNED COPY OF YOUR INSURANCE CARD, FRONT AND BACK

SECTION 2: PERSONAL MEDICAL HISTORY — To be completed by student

	Y	N	Year		Y	N	Year		Y	N	Year		Y	N	Year
Anemia or Sickle Cell anemia				Chest Pain Or pressure				Headaches (frequent/severe)				Protein or blood In urine			
Anorexia/Bulimia				Chronic Cough				Head Injury (severe)				Chronic pain (severe/recurrent)			
Allergies/Hay fever				Concussion				Hepatitis or jaundice				Pneumonia			
Asthma				Cancer or Tumor				Hearing Loss				Rectal disease			
Arthritis				Smoking				Hernia Specify:_________				Rheumatic or Scarlet fever			
Alcohol/Drug problem				Diabetes Type I or II:_____				Intestinal Problems				Seizures			
Breathing/Bronchitis Problems				Dizziness or Fainting				Kidney Stone				Sexually Transmitted Infection (STI)			
Back or neck Injury				Depression or Excessive worry				Learning Disorder Specify:_________				Thyroid Trouble Or disease			
Bone, joint or Other deformity				Eye problem (not glasses)				Malaria				Tuberculosis			
Broken bone Specify:_________				Easy fatigability				Mononucleosis				Testicle Problems			
Bladder or kidney Infection				High blood Pressure				Menstrual Cramps (severe)				Other Specify:_________			
Blood Transfusion				Heart Condition				Physical Disability Specify:_________				Other Specify: ________			

MEDICATIONS: Please list any drugs, medicines, birth control pills, vitamins, minerals (prescription and nonprescription or herbal medicines) you use and indicate how often you use them?

Name of drug	Reason for taking drug?	How much are you taking and how often?
1.		
2.		
3.		
4.		
5.		

ALLERGIES: Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Allergen	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics Name: ___________________________			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals Specify:__________________________			
Insect bites			
Food allergies Name:___________________________			

	Yes	No	Explanation (specify when, where and why)
Have you ever been a patient in any type of hospital?			
Has your academic career been interrupted due to physical or emotional problems?			
Have you ever had any serious illness or injuries other than those already noted?			

OFFICIAL DOCUMENTATION OF IMMUNIZATIONS, INSURANCE CARD COPY, AND THIS FORM may be returned to our office via: scanned to holtonhealth@arbor.edu, fax: 833.561.2587 OR mailed to HHWS, 106 E. Main Street, Spring Arbor, MI 49283.

IMPORTANT INFORMATION - PLEASE READ AND COMPLETE

A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the the information is strictly confidential and will not be released to anyone without my written consent, except in an emergency or by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Holton Health and Wellness Services to release information from my record to a physician, hospital or other medical agency involved in providing me with emergency treatment and/or medical care.
(B) I hereby authorize any medical treatment for myself that may be advised or recommended by the providers of Holton Health and Wellness Services.

____ ____________________________________

Signature of Student **Date**

PARENTAL/GUARDIAN PERMIT – MUST BE COMPLETED IF STUDENT IS UNDER 18 YEARS OF AGE
The LAW requires that parental permission be obtained for medical treatment of minors. A parent or guardian should sign the following consent form so That medical treatment may be given to the student who is a minor. However, no major operation will be performed except in extreme emergency, without Parent/guardian being contacted and fully informed.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my daughter/son/ward.

(Signed)____(Relationship)_____________________________(Date)_____________________________