EDGEWOOD COLLEGE

Health Services

Student Health History Report

THIS FORM MUST BE COMPLETED PRIOR TO MOVING INTO THE RESIDENCE HALL

Please print in black ink

CONFIDENTIALITY NOTICE

The information contained on this health form is legally privileged and confidential and is intended only for the use of Edgewood College Health Center. The copying or distribution of this document is prohibited.

Name (Last)	(First)	MI	Student I.D.

Date of Birth (MM/DD/YY)	Age	Citizenship (Specify Country if Other)	Preferred Pronouns:
		US ☐ Other ☐	

Home Address			
City	**State**	**Zip**	**Student Cell Phone** ( )
Emergency Contact (Name and Phone) ( )			

PART 1. IMMUNIZATION RECORD (include all dates of immunizations below or attach print out of immunization record)

COVID-Vaccine type: Pfizer Moderna Johnson & Johnson Other (please circle one-state type if "other")	1	2	3	4
DIPTHERIA – PERTUSSIS – TETANUS (DPT)	1	2	3	4
TETANUS – DIPTHERIA Vaccine type: Td Tdap (please circle one)			1	2
MMR (Measles, Mumps, Rubella)			1	2
POLIO	1	2	3	4
VARICELLA (Chickenpox) **OR** if you have had Chicken Pox **Record the Year:**			1	2
HEPATITIS B		1	2	3
MENINGOCOCCAL				1
HPV VACCINE		1	2	3

PART 2. PERSONAL HEALTH HISTORY

MEDICAL OR HEALTH CONCERNS: Prior or current – Please check boxes below **IF NONE** apply, check this box ☐

Chicken Pox		Migraine Headaches		Thyroid Disease		Diabetes	
Whopping Cough		Ear, Nose, or Throat problems		Eczema		Hearing problems	
Polio		Sinusitis		Hives		Eating Disorder	
Tuberculosis		Tonsils removed		Back injury		Vertigo or Dizziness	
Hernia		Asthma		Heart problems		Ulcers	
Menstrual problems		Pneumonia		Kidney problems		Organ transplant	
Mononucleosis		Hypertension/Hypotension		Bladder problems		Surgery(specify)	
Hay Fever		Heart Murmur		Arthritis		Fracture(specify)	
Epilepsy (Seizures)		Rheumatic Fever		Bowel problems		Other (specify below)	

Allergies:

List current medication(s) and reason(s):

Do you have an illness or condition, including emotional or psychological, not listed above, for which you are receiving treatment? If yes, specify.

List date(s) and reason(s) for any hospitalizations:

Other pertinent medical information**:**

PART 3. EMERGENCY ROOM and URGENT CARE

We do not handle any insurance coverage/costs There is a minimal cost for visits or medications, which are billed to the student account. Please consult your insurance carrier to identify covered facilities within a 50-mile radius of Edgewood College. This enables us to provide appropriate referrals and helps avoid the need to search for this information in an urgent situation. If you do not have coverage within the region, we recommend you consider the student health plan. Since students are a healthy group in general, insurance premiums tend to be relatively low and may offer a savings over group family plans. See www.wpsic.com/waicu/ for plan information.

	URGENT CARE	EMERGENCY ROOM
FACILITY NAME		
LOCATION		

PART 4. STUDENT VERIFICATION

By signing below, I am certifying that the information on this form is complete and accurate to the best of my knowledge.

_____ _____

Student Signature Date

PART 5. AUTHORIZATION FOR TREATMENT

This is to be completed and signed by students (if student is under eighteen years old, this must also have the signature of the student's parent/guardian). In case of serious illness or accident, I give Edgewood College or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication, and surgery that is considered necessary for my good health. I agree to be responsible for all medical costs. In the event of a non-serious condition requiring minor care, I approve of care by Edgewood College's licensed professional nursing staff.

_____ _____ _____

Student Signature Parent/Guardian Signature Date

Please return form to:

Edgewood College Health Services
1000 Edgewood College Drive
Dominican Hall 123
Madison, WI 53711
Phone: (608) 663-8334
Fax: (608) 663-3394
healthservices@edgewood.edu