



LAKELAND COLLEGE HEALTH ASSESSMENT

Date _____

Name _____
(last) (first) (middle)

Home Address _____
(street) (city) (state) (zip)

Home Telephone () _____ Gender: ___ Male ___ Female

Date of Birth _____ Social Security # _____

Hospital/Health Insurance (Name) _____ Telephone _____

Name of Policy Holder _____ Policy Number _____

Home Physician _____ Phone Number () _____

May we contact your physician if the need arises? ___ Yes ___ No

If your answer to this question is yes, please sign here: _____
(If you are under 18 years of age, parent or guardian should sign.)

PLEASE COMPLETE ALL SECTIONS:

Father _____
(last) (first) (middle)

Home Address _____ Home Phone () _____

Work _____ Work Phone () _____

Mother _____
(last) (first) (middle)

Home Address _____ Home Phone () _____

Work _____ Work Phone () _____

Spouse _____
(last) (first) (middle)

Home Address _____ Home Phone () _____

Work _____ Work Phone () _____

OTHER EMERGENCY CONTACT: (Other than parents/spouse):

Name _____ Relationship _____

Address _____ Home Phone () _____

Work Phone () _____

REPORT OF MEDICAL HISTORY:

Yes No I have the following allergies (Please specify: foods, medicine, pollens, etc.)

I take medications or drugs regularly. (Please specify)

PREVIOUS INJURY OR SURGERY: lasting more than 3 days or requiring hospitalization. Give dates and explanation.

Head _____ Neck/Back _____ Shoulder _____ Chest _____ Abdomen _____ Arm _____ Elbow _____ Hand/Wrist _____
 Hip/Thigh _____ Knee _____ Lower Leg _____ Ankle _____ Foot _____ Other _____

CHECK CONDITIONS BELOW. If you indicate yes please provide date and brief explanation if necessary:

	Yes	No	Year
High blood pressure			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Chronic cough			
Tuberculosis			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			

	Yes	No	Year
Diabetes			
Mononucleosis			
Allergy injection therapy			
Arthritis			
Frequent or severe headaches			
Dizziness or fainting spells			
Epilepsy/Seizures			
depression			
Excessive worry or anxiety			
Intestinal trouble			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Broken bone (specify)			

	Yes	No	Year
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted disease			
Blood transfusion			
Smoke 1+ pack cigarettes/week			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Other (specify)			

REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
DTP or Td	(1)	(2)	(3)	(4)
Td Booster				
Polio	(1)	(2)	(3)	(4)
Measles (after first birthday)	(1)	(2)		**Titer Date & Result
Mumps				**Titer Date & Result
Rubella				**Titer Date & Result

TUBERCULIN (PPD) SKIN TEST (must be done within 12 months of coming to school)

Date administered _____ Date read _____ mm duration _____

Chest X-ray (if a skin test was positive or cannot be done) Date _____ Results _____

Was treatment indicated for positive skin test? NO _____ YES _____

If yes, what medication was taken? _____ Start date _____ End date _____