**STUDENT HEALTH HISTORY FORM**

# General Information:

( )

( )

(LAST NAME) (FIRST) (MIDDLE) (BIRTH DATE)

# Permanent Mailing Address:

Male

Female

(STREET) (CITY) (STATE) (ZIP CODE) (TELEPHONE)

**Health Problems**: I have the following health problems [*list any continuing health problems; write “****none****” if not applicable*]:

**Drug Allergies and Reaction**: I have the following drug allergies and reactions [*list any drug allergies and briefly describe what happened; write “****none****” if not applicable*]:

**Medicines**: I regularly take the following medicines [*include any pills or injections, prescription and over-the- counter medications; write “****none****” if not applicable*]:

**Medical History**: I have had the following [*check if* ***you*** *have ever had any of the following and explain below]*:

Anemia

Asthma or Allergies Arthritis or Back problems Bladder or Kidney problems

Blood Clot(s) or bleeding problems Cancer or Leukemia

Epilepsy, Seizure Disorder or Syncope (Fainting) High Blood Pressure

Ulcer or Inflammatory Bowel Disease Heart Problems

Migraine headache Eating Disorder

Psychosis or Schizophrenia Anxiety or Depression Substance Abuse

Surgery

None of the above

If you checked any of the above, please provide a brief explanation:

Have you ever lived in close contact with anyone who had tuberculosis? Yes No

*TB skin test*: negative year

 positive year

 never tested

*TB Medicines Taken*:

**Family Medical History** [*check if anyone in* ***your family*** *has have ever had any of the following health problems]:*

Blood Clots or Bleeding Problems Cancer

Diabetes Heart Disease

Sickle Cell Disease

Please use the space provided to inform us if there is anything else that is not covered by this form that we should be aware of:

# \* \* \* \* \* \* \* \*

In the event I require emergency medical care in connection with my participation in an overnight travel experience, I authorize Xavier to release the information provided on this form to medical personnel to facilitate that medical care. Xavier will not use the information disclosed on this form for any other purpose, including any assessment of my ability or fitness to participate in an overnight travel experience.

By signing below, I certify that I have accurately provided my health history information above.

Participant’s Signature Date

Banner ID: