HEALTH RECORD MVCS Resident Life

NAME OF STUDENT:____ AGE:________
ADDRESS:____
BIRTH DATE:________________________________

MEDICAL HISTORY
Check and give date of illness:

_____Rubella:____________________________ _____Mumps:______________________________
_____Rubeola:____________________________ _____Chickenpox:___________________________
_____ Whooping cough:_____________________ _____Polio:________________________________

Allergies -EXTREMELY IMPORTANT: Give history of all allergies, including **drug or food allergies**, and describe the reaction:____
____
____

Asthma -Include treatment, name of medications and frequency, frequency of attacks, number of ER room visits in the last year:____
____
____

Injuries and Fractures – Provide dates and sites:____
____

Operations – Provide dates and types: ____
____

Has student ever been treated by a mental health care professional? __________

If yes, give a brief description of condition:_ ____

Name of mental health care professional: ____

Address:____Phone:_____________________

Has student ever been treated for substance abuse issues? __________

If yes, give a brief description of treatment:____
____

Is student now under any medical treatment? YES _____ NO ____
If yes, please explain:____
____

Should any limitations or restrictions be placed upon student's activities? _________________________
____

Does student require any therapeutic measures or special care?______________
If yes, explain: ____
____

Does student take any medicine regularly or occasionally?_____________ (prescription or non-prescription)
If yes, list medicine and dosage:____
____
____