



CENTER FOR HEALTH AND COUNSELING SERVICES

505 Ramapo Valley Road, Mahwah, NJ 07430-1680
Counseling Services: Phone (201) 684-7521,7522 Fax (201) 684-7995
Health Services: Phone (201) 684-7536 Fax (201) 684-7534
www.ramapo.edu

**HEALTH HISTORY FORM FOR RAMAPO COLLEGE PROGRAMS,
SPECIAL EVENTS AND CONFERENCES**

The information on this form is not part of the participant's acceptance process but is gathered to assist Health Services in identifying appropriate care. Any changes to this form should be provided to the health personnel upon participant's arrival. Please provide complete information so that Ramapo College of NJ Health Services Department can be aware of your needs.

Name: _____ Birth Date _____
Last First Middle

Home Address _____
Street Address City State Zip

Social Security Number of Participant _____ Gender Female Male

Name of Program, Special Event or Conference EOF Governor's Program Upward Bound
 Other _____

Custodial Parent / Guardian _____ Phone _____

Home Address _____
If different from above Street Address City State Zip

Business Address _____ Phone _____
Street Address City State

Second Parent / Guardian or Emergency Contact _____

Address _____ Phone _____
Street Address City State

Business Address _____ Phone _____
Street Address City State

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical /hospital insurance? YES NO

If YES, indicate carrier or plan name _____ Group # _____

♦ Photocopy of front and back of insurance card must be attached to this form.

IMPORTANT -THIS SECTION MUST BE COMPLETED

Parent/ Guardian Authorization: This health history is correct and complete as far as I know and the Person herein Described has permission to engage in all activities except as noted.

I hereby give permission to Ramapo College of NJ, Health Services Department, to provide routine health care, prescribe medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Ramapo College of NJ, Health Services Department, to secure and administer treatment. In the event of transportation to a local hospital, I give permission for the transportation, the release of medical records and information to the hospital. I hereby give permission for the photocopy of this form for use in those situations.

Signature of parent / guardian _____ Date _____

Printed Name _____

Allergies Please list all known. Attach additional sheets as necessary.

Medication Allergies (list)	Please describe reaction and usual management for the reaction
_____	_____
_____	_____

Food Allergies (list)	Please describe reaction and usual management for the reaction
_____	_____
_____	_____

Other Allergies (list) Please include insect stings, hay fever, animal, etc.	Please describe reaction and usual management for the reaction.
_____	_____
_____	_____

Medication Currently Being Taken Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring enough medication to last while you are at Ramapo College of NJ. Please keep medications in original packaging / bottle that identifies the prescribing medical provider (for prescription drugs), as well as the name of the medication, the dosage, and the frequency of administration.

Attach additional pages as needed.

- This person **takes NO medications** on a routine basis.
- This person **takes medications** as follows:

Medication #1 _____ Dosage _____

Specific times when medication is taken each day _____

Reason for taking medication _____

Medication #2 _____ Dosage _____

Specific times when medication is taken each day _____

Reason for taking medication _____

Restrictions The following restrictions apply to this individual

Does not eat Red Meat Pork Dairy Products Poultry
 Seafood Eggs Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary.) _____

General Information Please explain all "YES" answers below

Has the participant:	YES	NO
1. Has any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness / condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had a back problem?	<input type="checkbox"/>	<input type="checkbox"/>
17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had skin problems (e.g., itching, rash, acne, hives)?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had problems with diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
23. If female, an abnormal menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
24. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
25. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "YES" answers, noting the number for each question before the response

Please use this area to provide any additional information about the participant's behavior, emotional, physical or mental health about which Health Services should be aware.

Name of Family Health Care Provider / Physician _____

Address _____ Phone _____
Street Address City State Zip