STUDENT HEALTH HISTORY *REQUIRED*

To better assist your medical needs, please answer the following questions as accurately as possible.
Please Note: *This information is confidential, housed in the Health Centers, and will not be released without your permission.*
If you are involved in a medical emergency this form will be provided to EMS on arrival.

Name ______________________ **DOB:** __________ **J#** ______________ **Phone** ______________
Preferred Name ______________________ **Sex** __________ **Gender Identity** ______ **Pronouns** ______________
Address ______________________ **City** __________ **State** ______________ **Zip** ______________
☐ **Please check if you reside at JCC** **Dorm Building:** ☐ North ☐ South ☐ West

Emergency Contacts
Name ______________________ Phone ______________________ Relationship ______________
☐ Check box if we are allowed to contact emergency contacts and share medical information.
Are you currently under a Doctor's care? ☐ Yes ☐ No If yes, please explain ______________
Doctor Information:
Do you use tobacco? ☐ Yes ☐ No If yes, please explain ______________
Do you use controlled substances? ☐ Yes ☐ No If yes, please explain ______________
Do you use Alcohol? ☐ Yes ☐ No If yes, please explain ______________

{ **Pregnant?** ☐ Yes ☐ No **Taking oral contraceptives?** ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No }

{ Allergies ____
☐ Please check box if you are prescribed an EpiPen }

Personal Medical History
Please answer yes or no below if you have had or are currently under treatment for any of the following:

	YES	NO		YES	NO		YES	NO
Alcoholism			Colitis			Hepatitis		
Anemia			Diabetes Type 1			Hypertension		
AIDS/HIV			Diabetes Type 2			Hypotension		
Anaphylaxis			Depression			Multiple Sclerosis		
Asthma			Deafness			Muscular Dystrophy		
Arthritis			Drug addiction			Skin Disorder		
Anorexia			Dizziness			Thyroid Disease		
Bulimia			Epilepsy			Tuberculosis		
Back disorder			Emphysema			Ulcers		
Bronchitis			Fainting spells			Other:		
Cancer			GERD					
Chemotherapy			Heart Disease					
Chest pains								

Medications:
Do you take any medicine regularly? ☐ Yes ☐ No If yes, please list below

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I hereby certify that, to the best of my knowledge, the information provided is true and accurate. I understand that the information provided will be used to assist in my care plan and further medical care when necessary. I understand that it is my responsibility to update medical information when necessary.

Signature (Guardian, if under 18): ______________________ Date: ______________
Name: ______________________