HEALTH REGISTRATION FORM

FISHER COLLEGE

Fisher College Health Services
118 Beacon Street, Boston, MA 02116
Phone: 617.236.8860 Fax: 617.236.5465

Student completes this form. Please return directly to Fisher College Health Services.

PLEASE NOTE: ALL STUDENTS are required to return the completed HEALTH and IMMUNIZATION REPORT by August 1 for fall enrollment and January 1 for spring enrollment. Students who are admitted after this date must bring their forms to check-in day. Any student failing to provide this required documentation will be prohibited from registering and attending classes.

INSTRUCTIONS: This form must be completed in ENGLISH. Please complete all forms labeled *STUDENT COMPLETES THIS FORM.* Please have the student's physician complete and return all forms labeled *PHYSICIAN COMPLETES THIS FORM.*

Name: _____ (Last / First / MI) Date of Birth: _____ (Month / Day / Year)

Legal Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Permanent Address: _____ (Street and Number / City / State / Zip)

E-mail Address: _____ Birthplace (Country): _____

Home Telephone: (_____) (_____) _____ (Country Code if International / Area Code) Cell Phone: (_____) _____ (Area Code)

Local Address: _____ (Street and Number / City / State / Zip)

Father/Guardian's Name: _____ Mother/Guardian's Name: _____

Father/Guardian's Home Phone: (_____) _____ Mother/Guardian's Phone: (_____) _____

Father/Guardian's Business Phone:(_____) _____ Mother/Guardian's Business Phone: (_____) _____

Semester/year entering Fisher College: _____ Status: ☐ Freshman ☐ Transfer Living: ☐ Resident ☐ Commuter

College(s) attended: _____ Dates attended: _____

Alternate Emergency Contact

Name: _____ (Last / First / Relationship)

Home Telephone: (_____) _____ Cell Phone: (_____) _____

E-mail Address: _____

CONSENT FOR EMERGENCY TREATMENT

To be signed by parent/guardian if student is under 18 years of age:

I give permission for medical treatment for my son/daughter

_____

In the event of an accident or illness, this includes referral to a local hospital, hospitalization, anesthesia, and/or surgery should it be necessary and I am unable to be reached.

_____
Signature Date

CONSENT FOR EMERGENCY TREATMENT

To be signed by student over 18 years of age:

I consent to care at Fisher College Health Services.

_____
Signature Date

FOR HEALTH SERVICES USE ONLY

Date Received: _____

Allergies: _____

_____

_____

_____

_____

☐ Complete ☐ Rubella ☐ CXR
☐ Exemption ☐ TDaP ☐ INH
Measles ☐ #1 ☐ #2 ☐ PPD ☐ Physical Exam
Mumps ☐ #1 ☐ #2 ☐ MCV ☐ Labs
Hepatitis B ☐ #1 ☐ #2 ☐ #3 Varicella ☐ #1 ☐ #2 ☐ CP

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Fisher College | www.fisher.edu

MEDICAL HISTORY

STUDENT COMPLETES THIS FORM

Student Name: _____

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FAMILY HISTORY

Please list all family members	Age	Health Status	Age at death	Cause of death
Father				
Mother				
Brothers				
Sisters				
Spouse				
Children				

Have any of your immediate relatives had any of the following:

Illness	✓ for yes	Specify which relative
Alcoholism/Substance Abuse		
Asthma or Allergies		
Blood or Bleeding Disorder		
Cancer		
Diabetes		
Heart Disease/ High Blood Pressure		
Kidney Disease		
Mental Illness (please specify):		
Seizure Disorder		
Tuberculosis		
Other (please specify):		

STUDENT'S HISTORY

Do you have now or have you ever had: *(check all that apply)*

1. ☐ Abnormal Pap
2. ☐ Anemia/Bleeding Disorder
3. ☐ Anorexia Nervosa/Bulimia
4. ☐ Appendectomy
5. ☐ Arthritis
6. ☐ Anxiety
7. ☐ Asthma
8. ☐ Bone or Joint Problem
9. ☐ Cancer/Malignancy
10. ☐ Chickenpox
11. ☐ Colitis/Ileitis
12. ☐ Diabetes
13. ☐ Depression
14. ☐ Frequent ear problems
15. ☐ Eye problem
16. ☐ Fainting
17. ☐ Severe head injury
18. ☐ Heart disease/problem
19. ☐ Heart murmur/click
20. ☐ Hepatitis/Jaundice
21. ☐ High blood pressure
22. ☐ HIV infection
23. ☐ Impaired mobility/paralysis
24. ☐ Individualized Education Plan
25. ☐ Irregular heartbeat
26. ☐ Irritable Bowel Syndrome
27. ☐ Kidney stone
28. ☐ Kidney disease/urinary infection
29. ☐ Learning disability
30. ☐ Malaria
31. ☐ Recurrent headache
32. ☐ Mononucleosis
33. ☐ Neuro-muscular disease
34. ☐ Phlebitis/deep vein clot
35. ☐ Pneumothorax
36. ☐ Positive TB test
37. ☐ Rheumatic fever
38. ☐ Seizure disorder
39. ☐ Sickle cell disease/trait
40. ☐ Testicular problem
41. ☐ Thyroid disease
42. ☐ Tuberculosis
43. ☐ Ulcer
44. ☐ Other serious illness or injury, mental illness (please explain below)

_____

_____

_____

Do you smoke? ☐ No ☐ Yes
How many cigarettes a day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes How often? _____
If you drink, how may drinks do you have on the average in one evening?

_____

Do you exercise? ☐ No ☐ Yes What type? _____
How often? _____

When you travel in a car, what percentage of the time do you wear a seatbelt?

_____ %

Do you wear a helmet when biking/roller blading? ☐ No ☐ Yes

Do you examine your breasts/testicles regularly? ☐ No ☐ Yes

Do you follow any special diet? ☐ No ☐ Yes
What kind? _____

Are you concerned about your eating patterns? ☐ No ☐ Yes

Or your weight? ☐ No ☐ Yes

Do you consider yourself:
☐ underweight ☐ overweight ☐ normal weight

Do you often have a feeling of being overwhelmed or depressed?
☐ No ☐ Yes

Have you ever received treatment or counseling for an emotional problem?
☐ No ☐ Yes

Are you concerned about your own drinking or drug use? ☐ No ☐ Yes

MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS:

(If any, provide details including dates, diagnoses, surgeries, etc.)

_____

_____

CURRENT MEDICATIONS:

_____

_____

ALLERGIES (Please specify):

_____

_____

GYNECOLOGICAL HISTORY

(female students only – check all that apply)

Age at onset of menstrual cycle: _____ Length of cycle: _____

Date of last PAP smear: _____ Result: _____

Have you ever had: ☐ Colposcopy (Date) _____

☐ Irregular periods/no periods ☐ Painful cramps ☐ PID ☐ STI ☐ PCOS

☐ Bleeding between periods ☐ Breast lumps/Fibrocystic Disease

Explain all positive answers (please include dates):

_____

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