William Rainey Harper College
1200 West Algonquin Road
Palatine, Illinois 60067-

STUDENT HEALTH RECORD CONFIDENTIAL

PLEASE PRINT CLEARLY IN BLACK INK ONLY

Health Services
A Building, Room 364
Phone: 847-925-6268
Fax 847-925-6053

Name _____ **Birth Date** _____/_____/_____
Last First Middle Initial

Harper ID# _____ **Gender** _____ ☐ **Veteran**

Telephone_____ _____ **Email Address** _____
Primary Secondary

Address _____
Street Town State Zip Code

Emergency Contact
Name:_____ Relationship:_____ Contact Number:_____

ROUTINE MEDICATIONS: (prescribed and/or over the counter)

_____ _____ _____ _____

MEDICATION ALLERGIES: Yes _____ No_____ **FOOD/ENVIRONMENTAL ALLERGIES:** Yes_____ No_____

If yes, please list_____

FAMILY HISTORY of health problems (heart disease, diabetes, cancer, etc.--include parents, grandparents, siblings, children--be specific):

_____

HOSPITALIZATIONS/SURGERIES (type and date) _____

_____

Have you ever had, or do you now have any of the following:

SOCIAL HISTORY / INJURY PREVENTION	No	Yes*	*If yes, estimate amount/frequency
Tobacco Use			
Exercise			
Alcohol/Drugs			
Do you wear a seat belt and/or helmet?			
Do you practice safe sex?			

Have you ever had, or do you now have any of the following:

	No	Yes*	*Explain yes answers
Headaches/migraines			
Eye disease			
Ear, nose and throat disease			
Heart problems or high blood pressure			
Breathing problems			
Abdominal pain or liver disease			
Back pain			
Cancer			
Diabetes			
Seizures			
Anxiety/depression/abuse			
Other mental health/learning concerns			
Tuberculosis			
Rheumatic fever or polio			
Bone or joint problems			

The above information is accurate_____ _____
Student Signature **Date**

PHYSICAL EXAMINATION – Must be completed by a licensed health care provider

PATIENT NAME _____ DOB _____

HEIGHT_____ WEIGHT_____ BP_____ PULSE_____ BMI _____

Date of last Tdap vaccination _____

Flu Shot _____

Oct-Mar Date given Manufacturer Lot # Exp. Date Site

TB SCREENING:

(May be completed with the Physical Exam):

PPD (1) _____ _____mm

Date given Manufacturer Lot # Exp. Date Site Date read Results

PPD (2) _____ _____mm

Date given Manufacturer Lot # Exp. Date Site Date read Results

PHYSICAL ASSESSMENT:

	Within Normal Limits	Abnormal	Explanation of Abnormalities
General survey			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth			
Neck			
Spine & back			
Thorax & lungs			
Breasts			
Heart			
Abdomen			
Extremities			
Musculoskeletal			
Neurological			

RECOMMENDATIONS/COMMENTS_____

_____

Please check one of the following: Health Career Program / Athletics Other: _____

____ Student MAY participate in the above programs without limitations.

____ Student may participate in physical education programs with the following limitations: _____

_____

____ Student should NOT participate in any physical education program.

_____ _____

Signature of health care provider **Date**

_____

Street address

_____

City State Zip Code Telephone

03/2018