



**William Rainey Harper
College**

1200 West Algonquin Road
Palatine, Illinois 60067-7398

**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: _____ Contact Number: _____ Relationship: (Circle one) Spouse/Guardian/Parent/other _____
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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 _____

Signature

Date

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

PATIENT NAME _____ DOB _____

HEIGHT _____ WEIGHT _____ BP _____ PULSE _____ BMI _____

(Optional Items) UA _____ HGB _____ HCT _____

Protein Sugar

Date of last Tetanus vaccination _____ Td or Tdap? _____ Lot # _____

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 / CNA 101** Other: _____

_____ Student MAY participate in the above program without limitations, is able to function as a nursing assistant including ability to lift 50 pounds and push 100 pounds

_____ 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 _____