Center for Health & Counseling Services

Health Services
505 Ramapo Valley Road, Mahwah, NJ 07430-1680
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 Services staff upon the participant's arrival to campus. 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*

Gender Assigned at Birth: [ ] Female [ ] Male Identified Gender: ________________

Program attending: [ ] EOF [ ] Upward Bound [ ] CIPL Program [ ] other: ___________________

Custodial Parent / Guardian if participant is a minor (under the age of 18 years at time of participation):

Name_________________ ________________________________ Phone ___________________

Home Address

____
If different from above *Street Address* *City* *State* *Zip*

Business Address ____ Phone __________________
Street Address *City* *State*

Second Parent / Guardian
Name ____ Phone __________________

Address ____
Street Address *City* *State*

Business Address ____ *Phone* __________________
Street Address *City* *State*

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Emergency Contact:

Name**:** ______________________________ Phone: __________________

Relationship ___________________________________

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.**

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 describe reaction and usual management for the reaction.
Please include insect stings, hay fever, animal, etc.

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Medication(s) 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. Please note that Ramapo College of NJ, Health Services Office, will not administer any medications and that the individual is responsible for the self-administration of medications. The Health Services Office will also not store or hold any medications.

Attach additional pages as needed.

☐ **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.)
____
____

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General Information Please explain all "YES" answers below.

Has the participant:

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

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*

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Parent / Guardian Authorization if participant is a minor: 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 basic health care and seek emergency medical treatment as deemed necessary. 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. I understand that Ramapo College of NJ, Health Services Department, will not administer any medications unless deemed imminently necessary.

I am also aware that Ramapo College of NJ, Health Services Office, will not administer any medications brought to campus for self-use and that the individual is responsible for the self-administration of medications. The Health Services Office will also not store or hold any medications.

Signature of parent / guardian ____ Date______________

Printed Name ____