BAY PATH COLLEGE
HEALTH QUESTIONNAIRE

This form is to be filled out by the student, parents or guardian of each student less who is entering Bay Path College either as a member of the freshman class or as a transfer from another college.

Name: _____ Date of Birth: _____
Last First Middle Month Day Year

Home Address: _____ Social Security #: _____
Street

_____ ( ) _____
City State Zip Code Telephone

Name of Parent or Guardian:

1. _____ _____
Name Relationship

_____ ( ) _____
Home: Street City State Zip Code Telephone

_____ ( ) _____
Business Address: City State Zip Code Telephone

2. _____ _____
Name Relationship

_____ ( ) _____
Home: Street City State Zip Code Telephone

_____ ( ) _____
Business Address: City State Zip Code Telephone

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL PROCEDURES

If student is under 18 years of age

I hereby authorize Bay Path College or their school designee to give permission for routine medical care or Emergency medical treatment and/or surgical procedures including transportation to a local hospital by Ambulance, if necessary.

I understand the contents of the form I am signing:

_____
Student Date

_____
Signature of parent or guardian

The information requested is confidential and will be used only to insure proper health care while attending Bay Path College.

FAMILY HEALTH HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father:					
Mother:					
Brothers:					
Sisters:					
Spouse:					
Children:					

Have any of your relatives ever had any of the following?

YES	NO	CONDITION	RELATIONSHIP	COMMENTS
		Alcoholism		
		High Blood Pressure		
		Cancer		
		Heart Disease		
		Diabetes		
		Mental/Emotional Illness		
		Stomach or Intestinal Disease		
		Kidney Disease		
		Epilepsy/Convulsions		
		Tuberculosis		
		Stroke/Blood Clotting problems		
		Marfan Syndrome		
		Sudden Death under age 50		

PERSONAL HEALTH HISTORY

Check at left of each item. If "yes", explain as appropriate. (Use back of sheet if necessary)

YES	NO	PAST ILLNESSES
		1. Hospitalization (date, reason)
		2. Operation (date, type)
		3. Serious Accidents
		4. Serious Illness
		5. Emotional Problems
		6. Psychiatric Treatments
		7. Other Significant Health problems (Specify)

YES	NO	HAVE YOU EVER HAD THE FOLLOWING:
		8. Chicken Pox
		9. Measles
		10. Tuberculosis
		11. Hepatitis (be specific) Hepatitis A Hepatitis B Hepatitis C
		12. Scarlet Fever
		13. Other (specify)
		ALLERGIES to MEDICATIONS and/or ENVIRONMENTAL FACTORS
		14. Penicillin
		15. Other antibiotics
		16. Other medications
		17. Life threatening reaction to insect bites, food, etc.
		18. Do you carry an epinephrine kit?
		19. Are you allergic to cigarette smoke?
		20. Are you allergic to dust and/or pollen?
		21. Heart/blood pressure medications?
		22. Tranquilizers/antidepressants?
		23. Insulin?
		24. Allergy injections?
		25. Other (specify)
		LIFESTYLE
		26. Alcohol (ounces per week)
		27. Cigarettes per day How many years have you smoked?
		28. Do you diet frequently?
		29. Do you exercise regularly?
		30. Do you wear a seatbelt?
		HAVE YOU EVER HAD:
		31. Migraine headaches (diagnosed by M.D.)
		32. Epilepsy (convulsion)
		33. Paralysis or disability
		34. Thyroid problem
		35. High blood pressure
		36. Any heart problems
		37. Asthma
		38. Gastrointestinal complaints
		39. Gallbladder disease
		40. Head injury or concussion
		41. Chronic or persistent respiratory infection
		42. Urinary tract infection
		43. Gynecological problems
		44. Sexually transmitted disease
		45. Disease or injury of the joints
		46. Insomnia
		47. Dental problems
		48. Kidney disease
		49. Cancer
		50. Fainting or dizziness associated with exercise

YES	NO	HAVE YOU EVER HAD:
		51. Back problems
		52. Anorexia/Bulimia
		53. Mono (diagnosed by M.D.)
		54. Diabetes
		55. High blood pressure
		56. Immune Deficiency problems
		CURRENT HEALTH STATUS
		Height: Weight:
		57. Are you currently in psychiatric counseling?
		58. Are you currently receiving treatment for a medical condition?
		59. Do you require special housing arrangements?
		60. Do you require any special diet?
		61. Are there any medications you expect to continue while at Bay Path College? List below:
		62. Have you had any physical or emotional problems that have affected your classroom attendance during high school?
		63. Have you had any physical or emotional problems that have affected your classroom attendance at Bay Path College?

Are there any questions in regard to student's health, or other concern, which should be discussed with a member of the staff of Health Services or with members of the college faculty or administration. (attach paper if necessary)
Please explain: _____

_____

Health Insurance Information:

Name:_____ Social Security #:_____
Last First Middle

Name of Policy: _____ Address: _____

Subscriber' Full Name: _____ ID#: _____ Group#: _____

Choosing College Policy: YES _____ NO _____

I certify that this information is accurate and correct to the best of my knowledge and has not been misrepresented in any way.

Student: _____Date:_____

Parent or Guardian (if student is under 18 years of age): _____Date:_____