



Please return all forms to:  
**PARTON HEALTH CENTER**  
**5110 MIDDLEBURY COLLEGE**  
**MIDDLEBURY VT 05753**  
 Tel: 802-443-5135  
 Fax: 802-443-2066

Name \_\_\_\_\_  
LAST FIRST

Class \_\_\_\_\_ Social Security #: \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
month / day / year

A completed Middlebury College Health Form is required prior to course registration. Forms are due:  
**July 1 for September matriculation**  
**October 31 for February matriculation**

Instructions for Completing Health Form: Check box if you plan to participate in intercollegiate sports

1. Complete the Personal Health History, Sources of Health Care/Insurance/Emergency Notification sections prior to your physical exam.
2. Have your Health Care Provider complete the Entrance History & Physical and Immunization Record sections. If you have had a physical within the last 12 months your doctor does not need to perform another exam but does need to complete and sign the forms. **If you have had chicken pox please complete that section of your Immunization Record.**
3. Return all forms at one time in the enclosed self-addressed envelope.
4. Keep a photocopy of the completed form - ask for a copy from your doctor. Bring the copy with you to campus in the event your doctor has not mailed the form by the deadline.

### PERSONAL HEALTH HISTORY

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Sinusitis				Jaundice or hepatitis				ADD/ADHD *(see below)			
Hearing Loss				Kidney or bladder infection				Learning disability			
Ear, nose, throat problems				Gallbladder/pancreatic problems				Frequent or severe headaches			
Eye trouble				Kidney stone				Epilepsy, seizures			
Fainting spells				Missing kidney/ paired organ				Paralysis			
Rheumatic Fever				Albumin or blood in urine				Concussion/ head inj.			
Shortness of breath				Abnormal Pap test				Migraines			
Congenital heart disease				Fibrocystic breasts				Worry or anxiety			
Mitral valve prolapse				Irregular menstruation				Clinical depression			
Pneumonia				Sexually transmitted infection				Alcohol or drug use			
Asthma				Neck or back injury				Cigarette/tobacco use			
Chronic cough				Shoulder injury				Tumor or cancer			
TB/Positive TB test				Arm injury				Obesity			
Skin disease				Knee injury				Positive HIV test			
Hernia				Ankle injury				Malaria			
Irritable bowel syndrome				Other leg injury				Anemia or other Blood Disorders			
Stomach or intestinal problems				Arthritis, rheumatism, or bursitis				Mononucleosis			
Diabetes				Other orthopedic problems				Eating disorder			
Thyroid problems				Heat intolerance				Vegetarian			
								Chicken Pox			

Comment on any **YES** answers:

### FAMILY HISTORY

Have parents, siblings, or grandparents had any of the following? If adopted and history unknown, check here

	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Cancer (type: _____)			
High Blood Pressure				Sickle cell anemia			
Stroke				Thyroid disease			
High Cholesterol				Depression/mental illness			
Heart attack before 55				Liver disease			
Alcoholism				Other serious illness			

If either parent or a sibling is deceased, list relationship to you, age at death, and cause of death:

---

## MEDICAL HISTORY

**Medications:** List all medications that you take regularly. Include meds for ADD/ADHD\*, depression, anxiety, disturbance of mood, thought or behavior, birth control pills, vitamins and minerals, nonprescription medications and supplements. Bring what you anticipate needing or a prescription from your physician.

---



---

**\*STUDENTS TAKING MEDICATION FOR ADD/ADHD WILL NOT BE ABLE TO OBTAIN PRESCRIPTIONS FOR REFILLS FROM PARTON HEALTH CENTER.**  
**PLEASE MAKE ARRANGEMENTS FOR REFILL PRESCRIPTIONS WITH YOUR PRESCRIBING PRACTITIONER.**  
*IF YOU ARE AN INTERCOLLEGIATE ATHLETE ON MEDICATION FOR ADD/ADHD, YOU MUST HAVE YOUR DOCTOR COMPLETE THE **ADHD MEDICATION INFORMATION EXEMPTION FORM** SENT TO YOU BY SPORTS MEDICINE.*

**Allergies:** List known allergies and type of reaction to:

Medication \_\_\_\_\_

Foods \_\_\_\_\_

Environment \_\_\_\_\_

Do you receive allergy desensitization injections?

No  Yes Name of allergist \_\_\_\_\_

Address \_\_\_\_\_

Telephone / Fax \_\_\_\_\_

If you wish to continue allergy injections at Parton Health Center, you must bring your serum, complete instructions and injection schedule. Please read detailed information on our Health Center website: <http://www.middlebury.edu/campuslife/services/health/allergyshots.htm>

**Hospitalizations:** Have you ever been hospitalized for any medical illness or surgery?

No  Yes: specify diagnosis and date: \_\_\_\_\_

---



---

## MENTAL HEALTH HISTORY

Have you received counseling or been hospitalized for mental health or psychiatric care within the last six years?

No  Yes: specify diagnosis and date (include worry, anxiety, clinical depression, alcohol or drug use, disordered eating): \_\_\_\_\_

---



---

## SOURCES OF HEALTH CARE

List the names, addresses and telephone numbers of physicians, psychologists, or other health care providers you now consult.

Name _____	Name _____
Specialty _____	Specialty _____
Address _____	Address _____
City, State _____	City, State _____
Telephone _____	Telephone _____
Fax _____	Fax _____

## HEALTH INSURANCE COVERAGE

Middlebury College requires all students have personal health insurance. **Please provide 2 copies of both sides of your insurance card. If you do not have insurance, you are required to purchase the Sickness Insurance through the College.** Information is available at: <http://www.middlebury.edu/campuslife/services/health/insurance.htm>

---

Insurance Company	Address	Group and Policy #
Subscriber's Name	Subscriber's DOB	Subscriber's SS#

**EMERGENCY NOTIFICATION**

Please provide the name of your parent/guardian and someone other than your parent/guardian to call if a parent/guardian is not available. Please don't list mother and father separately if they live in the same home.

Name _____ Relationship _____ Address _____ City, State, Zip _____ Telephone _____ Home                      Work _____ Cell _____	Name _____ Relationship _____ Address _____ City, State, Zip _____ Telephone _____ Home                      Work _____ Cell _____
--	--

**SPECIAL POWER OF ATTORNEY WOULD BE EVOKED IF PARENTS/GUARDIANS COULD NOT BE REACHED**

(For students less than 18 years old)

The undersigned, being the person(s) entitled to custody of \_\_\_\_\_, a minor born on \_\_\_\_\_, hereby appoint the Dean of the College/Dean of Commons of Middlebury College, or his/her designate, as attorney for the sole purpose of giving or withholding consent to treatment of said minor in any health care institution as an inpatient, outpatient, or otherwise, and to giving and withholding consent to any medical and or surgical procedure, use of radiological procedures, administration of anesthesia, giving or receiving blood, or any of its components and any and all other types of treatment by health care institutions and/or health care professionals and their assistants.

This Special Power of Attorney shall remain in effect for one (1) year from the date hereof or until such prior date as the above minor shall attain majority under the laws of Vermont.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

The information you provide will be held in confidence as part of your student record at Parton Health Center and the Center for Counseling and Human Relations. If you are a member of an intercollegiate team or on the crew or rugby teams, Your Health Form will be reviewed by the Sports Medicine Department. The contents of your health file will not jeopardize your admission to Middlebury College as you have already been accepted. Information on this form or in your health record will not be released to anyone, even your parent(s)/guardian, without your consent, except in situations that endanger your health or life.

My signature below indicates that:

- I consent to medical and nursing treatment by the Middlebury College Parton Health Center staff.
- The information on this form is correct and complete to the best of my knowledge.
- I understand that Middlebury College views my health as chiefly my responsibility.
- If I require services, prescriptions, or referrals beyond the primary care services available at Middlebury College Parton Health Center, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.
- I understand that my contacts with health services are held in confidence, but that confidentiality may be broken if my health or that of another person is in danger.

Signature of student \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

(Required if student is not yet 18 years old or if insurance listed above is in parent's or guardian's name.)

**ENTRANCE HISTORY AND PHYSICAL**

[Physical exam required within the past 12 months. To be completed by MD, NP, or PA and signed at the bottom]

Ht:	Wt (gown/underwear):	B/P:	Pulse:	Hgb/Hct:
Urinalysis:	SpGr:	Sugar:	Protein:	Micro if indicated:
Women:	Age at Menarche	# Menses in last 12 mos	Date of last PAP <small>Provide results if abnormal</small>	

	Normal	Abnormal		Normal	Abnormal
General Development			Breasts		
Head, face, scalp, skull			Abdomen (inc hernia)		
Eyes			Genitals (inc testicular exam)		
Ears			Extremities		
Nose and Sinus			Musculoskeletal		
Throat, neck, thyroid			Lymph glands		
Skin			Rectal (if indicated)		
Lungs			Neurological		

Comment on any *ABNORMAL* findings:

Is the person currently under treatment for any medical or emotional condition?  
 No  Yes: specify \_\_\_\_\_

STUDENTS TAKING MEDICATION FOR ADD/ADHD WILL NOT BE ABLE TO OBTAIN PRESCRIPTIONS FOR REFILLS FROM PARTON HEALTH CENTER.  
 PLEASE MAKE ARRANGEMENTS FOR REFILL PRESCRIPTIONS WITH YOUR PATIENT.  
 IF YOUR PATIENT IS AN INTERCOLLEGIATE ATHLETE ON MEDICATION FOR ADD/ADHD, YOU MUST COMPLETE THE **ADHD MEDICATION INFORMATION EXEMPTION FORM** SENT TO HIM/HER BY SPORTS MEDICINE.

**CARDIAC SCREENING** (to be completed by MD, NP, or PA)

**HISTORY**

	No	Yes		No	Yes
Chest pain with exercise			Hypertrophic cardiomyopathy (HCM)		
Fainting or dizziness with exercise			Dilated cardiomyopathy		
Heart races/skips beat with exercise			Long Q-T syndrome		
Hypertension			Marfan's Syndrome		
Family H/O sudden death before age 50			Clinically important arrhythmias		
Family H/O heart disease before age 50			Heart murmur		

Comment on any *YES* responses:

**HISTORY OF ECHO, ECG, TREADMILL TEST OR CARDIOLOGY CONSULT SEND COPY OF RESULTS WITH THIS FORM**

**CARDIAC EXAM**

Brachial blood pressure (sitting) \_\_\_\_ / \_\_\_\_

		Normal	Abnormal	Explain abnormal findings: <small>Murmurs that soften with squatting or are louder/longer with standing or valsalva should be evaluated for HCM or MVP.</small>
Precordial Auscultation	Supine			
	Squatting			
	Standing			
	Standing with valsalva			
Femoral Artery pulses				
Physical stigmata for Marfan Syndrome ( <a href="http://www.marfan.org">www.marfan.org</a> )		<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, consider ECG and send result

LIST ANY RESTRICTIONS: \_\_\_\_\_

HEALTH CARE PROVIDER \_\_\_\_\_  
PRINT SIGNATURE

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_ DATE \_\_\_\_\_

THE SIGNING HEALTH CARE PROVIDER IS RESPONSIBLE FOR ANY INCORRECT OR MISSING INFORMATION