



STUDENT HEALTH HISTORY *REQUIRED*

To better assist your medical needs, please answer the following questions as accurately as possible.
Please Note: This information is confidential, housed in the Health Centers, and will not be released without your permission.
If you are involved in a medical emergency this form will be provided to EMS on arrival.

Name _____ DOB: _____ J# _____ Phone _____
Preferred Name _____ Sex _____ Gender Identity _____ Pronouns _____
Address _____ City _____ State _____ Zip _____
☐ Please check if you reside at JCC Dorm Building: ☐ North ☐ South ☐ West

Emergency Contacts

Name _____ Phone _____ Relationship _____

☐ Check box if we are allowed to contact emergency contacts and share medical information.

Are you currently under a Doctor's care? ☐ Yes ☐ No If yes, please explain _____

Doctor Information:

Do you use tobacco? ☐ Yes ☐ No If yes, please explain _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain _____

Do you use Alcohol? ☐ Yes ☐ No If yes, please explain _____

{ Pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No }

{ Allergies _____
☐ Please check box if you are prescribed an EpiPen }

Personal Medical History

Please answer yes or no below if you have had or are currently under treatment for any of the following:

	YES	NO		YES	NO		YES	NO
Alcoholism			Colitis			Hepatitis		
Anemia			Diabetes Type 1			Hypertension		
AIDS/HIV			Diabetes Type 2			Hypotension		
Anaphylaxis			Depression			Multiple Sclerosis		
Asthma			Deafness			Muscular Dystrophy		
Arthritis			Drug addiction			Skin Disorder		
Anorexia			Dizziness			Thyroid Disease		
Bulimia			Epilepsy			Tuberculosis		
Back disorder			Emphysema			Ulcers		
Bronchitis			Fainting spells			Other:		
Cancer			GERD					
Chemotherapy			Heart Disease					
Chest pains								

Medications:

Do you take any medicine regularly? ☐ Yes ☐ No If yes, please list below _____

I hereby certify that, to the best of my knowledge, the information provided is true and accurate. I understand that the information provided will be used to assist in my care plan and further medical care when necessary. I understand that it is my responsibility to update medical information when necessary.

Signature (Guardian, if under 18): _____ Date: _____

Name: _____