Lasell College Health Services
1844 Commonwealth Avenue
Newton, MA 02466
(617) 243-2216
Fax: (617) 243-2339

STUDENT HEALTH HISTORY

Athletics: Check here if you plan to participate in varsity sports ❒

Name _____ Date of Birth _____ Gender _____
Last **First**

Home Address _____ City _____ State _____ Zip _____

Home Phone # _____ **Student Cell Phone #** _____
Include Country Code if International Area Code

IN CASE OF EMERGENCY NOTIFY: _____ Phone # _____ Relationship _____

Health Insurance Plan: _____ ID# _____ Group # _____

Health Insurance Plan Address _____ Subscriber Name: _____

CONSENT FOR TREATMENT OF MINORS:

I consent to have my child _____ receive routine care at Lasell College Health Services or local hospital should he/she become ill, injured or require emergency care while at school.

Parent/Guardian's Signature _____ Date _____

FAMILY HISTORY:

Relation	Age	General Health	Past/Present Serious Illness	If Deceased Age at Death	Cause of Death
Father					
Mother					
Brother/Sister					
Brother/Sister					
Brother/Sister					

PERSONAL HISTORY:

ILLNESS	Y	N	AGE	ILLNESS	Y	N	AGE	ILLNESS	Y	N	AGE	ILLNESS	Y	N	AGE
ADHD/ADD				Cancer				Headaches				Mononucleous			
Allergies				Diabetes				Heart				Panic Disorder			
Anemia				Depression				Hepatitis				Sleep Issues			
Anxiety				Eating Disorder				High Blood Pressure				Thyroid			
Asthma				Eye or Ear				Kidney or Urinary				Tuberculosis or (+) PPD			
Bone & Joint				Gastrointestinal				Menstrual Problems				Other			

1. **Are you allergic to any medicines?** Yes ❒ No ❒ Which ones? _____
2. Are you being followed by a physician for any medical problems? Explain _____
3. Are you taking any medicine? Name & dose _____
   Reason _____
4. Have you received counseling or been hospitalized for worry, anxiety, depression, alcohol or other drug use, disordered eating or other mental/emotional health care? Yes ❒
   Explain _____
5. Date and type of any hospitalizations, injuries, (athletic & nonathletic), and surgical operations which you have had. _____
6. Other medical problems _____
7. Will you need specific medical care?
   Reason _____

I hereby certify that the information entered above is complete and accurate.

Date: _____ Student's Signature _____