FOR GRADUATE STUDENT USE ONLY

LUX ET SPES

STONEHILL COLLEGE

DEADLINES

AUGUST 1 FALL SEMESTER

JANUARY 1 SPRING SEMESTER

MAY 1 SUMMER SEMESTER

ALL graduate students are required to return the Graduate Health and Immunization Report to Health Services by the deadline. Students who are admitted to the program after the official enrollment deadline should coordinate with the Office of Health Services to ensure the required health forms are submitted before the start of classes.

Stonehill College Health Services
320 Washington Street
Easton, MA 02357-5710

Phone: 508-565-1307
Fax: 508-565-1510
stonehill.edu/health

Please make a copy for your records.

FOR HEALTH SERVICES USE ONLY
Date received:
All requirements complete: Y N

STUDENT INFORMATION

Name

Address

City State ZIP

Home phone

Cell phone

Email

Date of Birth

Gender

Birthplace

Stonehill ID#

Date Entering Stonehill College

PRIMARY EMERGENCY CONTACT

Contact Name

Home phone

Cell phone

Relationship

SECONDARY EMERGENCY CONTACT

Contact Name

Home phone

Cell phone

Relationship

MEDICAL HISTORY: You are required to provide this information truthfully and accurately.

Student's Last Name | First Name | Middle Initial | Date of Birth

FAMILY HISTORY (immediate relatives, which includes parents and siblings)

Name + Relationship | Age | State of Health

Name + Relationship | Age | State of Health

Name + Relationship | Age | State of Health

Name + Relationship | Age | State of Health

Name + Relationship | Age | State of Health

Name + Relationship | Age | State of Health

Have any of your immediate relatives had any of the following:

Ailment	Relationship
☐ Alcoholism	_____
☐ Asthma or Allergies	_____
☐ Blood or Bleeding Disorder	_____
☐ Cancer	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ Kidney Disease	_____
☐ Mental Illness	_____
☐ Seizure Disorder	_____
☐ Tuberculosis	_____

PERSONAL HISTORY

- ☐ Acne
- ☐ Anemia
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ Blind/visual Impairment
- ☐ Cancer/Malignancy
- ☐ Celiac Disease
- ☐ Concussions
- ☐ Crohn's/Colitis/IBS
- ☐ Deaf/Hearing Impairment
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emotional/Mental Illness
- ☐ Heart Disease/Problem
- ☐ Hepatitis (Type_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Infection/Disease
- ☐ Impaired Mobility/Paralysis
- ☐ Kidney Stone
- ☐ Kidney Disease
- ☐ Learning Disability_____
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Neuromuscular Disease
- ☐ Phlebitis/Deep Vein Clot
- ☐ Pneumothorax
- ☐ Positive TB Test
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Special Diet/Dietary Restrictions
- ☐ Thyroid Disease
- ☐ TB/Tuberculosis
- ☐ Ulcer/Stomach Problem
- ☐ UTIs (frequent)
- ☐ Other_____

Explain all positive answers, and please include dates: _____

MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS: _____

MEDICATIONS: Prescription, Over-the-counter, and Herbal _____

ALLERGIES: Medications, Food, Insect Venom, Latex _____

Please check the box for "yes" or "no" and answer accompanying questions.

☐ Yes ☐ No Do you smoke/vape/use other forms of tobacco or nicotine products? What type and how often? _____

☐ Yes ☐ No Do you drink alcohol? How often do you drink? _____

☐ Yes ☐ No Do you use any recreational or non-prescribed drugs? What type and how often? _____

☐ Yes ☐ No Have you ever received treatment/counseling for an emotional/mental health issue? _____

Dates of treatment: _____

Is there anything else that would be helpful for Health Services to know about your medical history in case of emergency?

_____

_____

_____

_____

_____