

HEALTH SERVICES



Oakton Community College

1600 East Golf Road, Des Plaines, IL 60016 • 847-635-1885 • Fax 847-376-7010
7701 North Lincoln Avenue, Skokie, IL 60077 • 847-635-1419 • Fax 847-376-7650

Confidential Medical History

To be completed by student and returned to Health Services. Please print.

Program you are entering is _____ **Date program starts:** _____

Last name _____ First _____ M.I. _____ (Maiden) _____

Social Security number _____ - _____ - _____ Date of Birth _____ Sex Female Male

Address _____ City _____ State _____ Zip _____

Phone (____) _____ Person to notify in an emergency: Phone (____) _____ Relationship _____

Have you ever had any serious injuries, major illnesses or operations? No Yes If yes, give details: _____

Have you ever had	Rubella (German Measles)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you now have	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Rubeola	<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Epilepsy (seizures)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other conditions of which Health Service should be aware? No Yes If yes, please explain: _____

Can you perform all the functions required of a student assigned to a participating health care setting at an affiliating institution with or without accommodation? No Yes If you require accommodation, please explain. _____

Are there any foods or medications you are allergic to? No Yes If yes, give details: _____

When was your last _____ / _____ / _____ physical examination? _____ / _____ / _____ Tetanus Booster? _____ / _____ / _____ Chest x-ray or TB skin test?

Consent to release medical information

I give my permission for the Health Service to release a physician's statement to the chairperson and designated liaison at any affiliating institution of the program in which I am enrolled. I understand that withholding information or giving false information on this form can warrant my dismissal from the program.

Signature _____ Date _____

NO student will be allowed to attend clinical classes until health forms are completed and returned to Health Services.