

Name: _____

PUC ID#: _____

HEALTH INFORMATION FORM



Return this form to:
Pacific Union College
Health Services
One Angwin Avenue
Angwin, CA 94508
Attn: Health Services

Phone (707) 965-6339
Fax (707) 965-6243

To avoid delays please
submit form for:
Fall Quarter: by Aug. 1
Winter Quarter: by Nov. 15
Spring Quarter: by Feb. 1
Summer Quarter: by May 15

Please complete form in its entirety before submission

Check one of the following:

- First Year (never attended PUC before). Starting quarter: Fall Winter Spring Summer
 Returning Student (last school year attended _____)

PLEASE PRINT IN INK

Full Legal Name:

Last

First

Middle

Date of Birth: _____ / _____ / _____ Sex: _____ Social Security No.: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Next of kin or person to be notified in emergency (off campus):

Name: _____ Relationship: _____

Street Address: _____

City/State/Zip: _____ Home Phone: _____

Work Phone: _____

Person to be notified in emergency (on campus):

Name: _____ Phone: _____

Insurance Information

Whether or not you have existing insurance you are required to go to aetnastudenthealth.com/puc to complete the process to waive out or enroll in the Aetna Student Health plan. To successfully complete this requirement you must be enrolled, taking 6 or more units, and accessing the website during the correct timeframe (30 days prior to two weeks after instruction begins). For more details please go to puc.edu/campus-services/student-health-insurance (707) 965-6339 or contact Aetna customer service at (877) 480-4161 8:30 a.m.-5:30 p.m. EST. It is no longer necessary to submit a copy of your existing insurance in lieu of the above requirement.

CHILDHOOD IMMUNIZATION RECORD: Please submit with your health documents a copy of your childhood immunizations. Please be aware that all news/transfer students must have a TB skin test within one year of your first quarter at PUC. This can be obtained either through your primary care physician or our office once you arrive on campus.

MEDICAL INFORMATION

List any allergies to medication: _____

List all medication taken regularly: _____

List all major injuries/hospitalizations: _____

PERSONAL HISTORY

If you mark "Yes" to any item please give dates.

Yes No

- Alcoholism
- Allergies
- Anemia
- Arthritis
- Asthma
- ADD/ADHD
- Back trouble
- Brain concussion
- Cancer
- Chickenpox
- Colds (frequent)
- Colitis
- Constipation
- Depression
- Developmental Disorder
- Diabetes
- Eating disorder
- Eczema
- Epilepsy

Yes No

- Fainting spells
- Fatigue
- German measles
- Glandular disorder
- Hay fever
- Headaches
- Hepatitis
- Hernia or rupture
- High blood pressure
- Influenza
- Jaundice
- Measles
- Meningitis
- Mental illness
- Mononucleosis
- Mumps
- Nervousness
- Pneumonia

Yes No

- Poliomyelitis
- Rheumatic fever
- Scarlet fever
- Sinusitis
- Sleeplessness
- Sore throat (frequent)
- Suicide attempts
- Tonsillitis
- Tuberculosis
- Typhoid
- Ulcers (stomach/duodenal)
- Whooping cough
- Born or raised in foreign country
Where? _____

- Other _____

FAMILY HISTORY

Check (X) in box indicating the illnesses your blood relatives have or have had (Indicate which relative):

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Obesity (20 lbs overweight) |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Suicide or attempts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tremors, palsy |
| <input type="checkbox"/> Bleeding trait | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Other |
| <input type="checkbox"/> Congenital defect | <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Other |

Student's Signature: _____

Name: _____

PUC ID#: _____

**CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY/ RELEASE OF INFORMATION /
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT**

I give my consent for medical treatment provided by the health services office of Pacific Union College.
I certify all submitted medical documents are correct.

I understand to be an enrolled student at PUC I am responsible to carry my own primary medical insurance plan and it is my responsibility to verify with my carrier adequate coverage in the Napa Valley. I understand PUC is not responsible for payment (either primary and/or secondary) for services received off campus.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and health information used by us in any form are kept confidential. This act gives patients seen significant new rights to understand and control how your health information is used. HIPPA provides penalties for misuse of personal health information. If you wish to review these rights we can provide you with a copy of the HIPPA Privacy Practice through our office.

You have the following rights with respect to your health information:

- The right to access, inspect, and request a copy of your health records.
- The right to request an amendment to your health information.
- The right to receive and account for certain disclosures of your health information.
- The right to receive confidential communications.
- The right to request restrictions on disclosures concerning your health information.

I hereby consent that medical information and treatment can be discussed with the following person/persons.
(If you request information to be discussed only with you please leave the following section blank).

Name: _____ Date: _____

Relationship to student: _____

Name: _____ Date: _____

Relationship to student: _____

Name: _____ Date: _____

Relationship to student: _____

Signature of student (over 18): **X** _____ Date: _____

Signature of parent (under 18): **X** _____ Date: _____

Name: _____

PUC ID#: _____

Date: _____

PHYSICAL EXAMINATION

The following to be completed by doctor's office staff. All information below is required. Please do not leave any section blank. We cannot accept "not applicable" in any category listed below.

Height: _____ **Weight:** _____

Hearing Evaluation:

Right: _____ Left: _____

Vision Screening:

Without glasses/With glasses (circle)

Right: _____ / _____

Left: _____ / _____

Vital Signs:

T: _____

P: _____

R: _____

B/P: _____

TB Test (within the last year)

Lot #: _____ Exp.: _____

Date given: _____ Date read: _____

Induration/reading: _____

Read by: _____

If you have recently been out of the United States, please have one done now. PPD must be negative-10mm or less.

Date of last chest X-ray: _____

Results: _____

Current Medications: _____

Nurse's Signature: _____

Remarks (please describe each abnormality): _____

Date of examination: _____

Physician's Signature: _____ Date: _____

Name of physician: _____ Street Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

To be filled out by physician:

Normal	Clinical Evaluation	Abnormal
	Head, Face, & Scalp	
	Nose & Sinuses	
	Neck	
	Mouth & Throat	
	Ears	
	Eyes	
	Lungs & Chest	
	Breast	
	Heart	
	Vascular System	
	Abdomen	
	Endocrine	
	G.U. System	
	Extremities	
	Musculoskeletal	
	Skin	
	Neurological	
	Emotional	