ST. THOMAS AQUINAS COLLEGE
Health Services
125 Route 340, Sparkill, New York 10976-1050
Tel: 845-398-4242 Fax: 845-398-4240
www.stac.edu

Name_____

DOB___/___/___ **Have you ever had? Please answer all questions. Explain all "yes" answers.**

Gastrointestinal Disorder □ Yes, _____

High Blood Pressure □ Yes, _____

Heart Murmur □ Yes, _____

High Cholesterol □ Yes, _____

Cancer □ Yes, _____

Arthritis □ Yes,_____

Anemia □ Yes, _____

Orthopedic/Spine Disorder □ Yes, _____

Clotting Disorder □ Yes, _____

Head Injury □ Yes, _____

Migraines □ Yes, _____

Asthma □ Yes, _____

Seizures □ Yes, _____

Student ID#_____

Cell phone_____

Surgery □ Yes, _____

Lung Problems □ Yes, _____

Dizziness/Fainting □ Yes, _____

Cardiac Disease □ Yes, _____

Tuberculosis □ Yes, _____

Thyroid Disease □ Yes, _____

Chicken Pox □ Yes, _____

Kidney Disease □ Yes, _____

Urinary Infections □ Yes, _____

Mental Health Diagnosis □ Yes, _____

Other: _____

□ **History reviewed, no significant medical history, no to all above.**

Do you have any physical, (temporary or permanent), or emotional problems of which the College should be aware in order to assist you in the achievement of your educational goals?

Yes _____ No _____ I f yes, please describe: _____

List Medications regularly taken or required: _____

Allergies: Food, medications, insects: _____

I give permission for the release of information concerning my medical condition to members of the Behavioral Response Intervention Team and Athletic Trainer (Athletes only) when necessary to deliver assistance to the student and when such information is required to ensure the safety of the student, STAC community, and/or when such disclosure is required by law.

Signature (Parent/Guardian if student is a minor) _____ Date_____