Bates Health Services
31Campus Ave.
Lewiston, ME 04240
Phone: 207-786-6199
Fax: 207-786-8240

Bates College Health History Form

(Confidential)

Please answer every question
Submission of this form is required before students matriculate.

Gender Identity:
___Woman Man ___
___Trans (please specify)_____
___Another Identity

Preferred Name: _____

Pronouns: _____

Legal Name | Last Name | First Name | Middle Initial

Cell Phone# | Date of Birth | Place of Birth | Student ID # | College Class

EMERGENCY NOTIFICATION

Please provide the names and contact information of two emergency contacts.

Contact 1_____
Name: _____ Street, City, State, Zip: _____

Telephone: Home_____ Cell_____ Email_____

Contact 2_____
Name: _____ Street, City, State, Zip: _____

Telephone: Home_____ Cell_____ Email_____

PERSONAL HEALTH HISTORY

1. Have you been diagnosed with a chronic medical condition, such as diabetes, seizures disorders, sleep disorders, etc., that would benefit from care coordination with the providers and support staff at Bates Health Services while you are a student? Yes _____ No____

2. Are you taking medication that you would like to transfer to a local provider or pharmacy while you are a student? Yes _____ No____

3. Are you taking medication for depression, anxiety, ADD/ADHD, disturbance of mood, thoughts or behavior? Yes _____ No____

4. Have you received counseling or psychiatric care within the last four years? Yes _____ No____

PRIMARY CARE PHYSICIAN

Name: _____

Office address: _____

Office Phone: _____ Office FAX: _____

MEDICAL HISTORY

CHRONIC MEDICAL CONDITIONS – Please List any Current Conditions

Medical Condition	Date Diagnosed	Current Care Plan

ALLERGIES

Allergies	YES	NO	Please List
Are you allergic to any medications?			
Are you allergic to any foods?			
Are you allergic to bee or other insect stings?			

MEDICATIONS – Please List Any Medication You are Currently Taking

Medication	Condition	Dosage (amount/frequency)	Side Effects	Restrictions

SURGERIES - Please list any recent major surgeries.

Reason	Dates	Result/Resolution

Student Signature: _____ Date:_____

Parent Signature: _____ Date:_____

Bates

Central Maine Medical Center
The Central Maine Medical Family

Consent to Medical Treatment

I voluntarily consent to such routine diagnostic procedures; medical and/or surgical care; and/or hospital care as determined by my provider and/or his/her designees to be necessary and desirable based on his/her exercise of professional judgment.

As the provider of medical services at Bates College, Central Maine Medical Center is a teaching hospital, students in medicine, nursing and other healthcare professions (under appropriate supervision) may be involved in my care. My treatment or physical condition will be electronically recorded in order to provide, coordinate, or manage my care. If this documentation includes a photograph, I will be asked to grant permission for such at the time of the visit and before a photograph is taken. I understand that my doctor will explain to me the purpose of the benefits and the usual and most frequent risks and hazards involved in the diagnosis and treatment of any illness or injury as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests or treatment.

I have the opportunity to make an Advance Directive and to place it in my medical record to give instructions about my care if I become unable to do so. I am aware that, if my heart or lungs should suddenly and unexpectedly stop working, cardio-pulmonary resuscitation (CPR) will be performed on me except in certain limited circumstances. CPR involves electric shock to the heart, mechanical breathing assistance through a tube inserted by mouth, drugs and other therapies. I can discuss my care, Advance Directive and CPR with my provider. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examinations, tests or treatment.

I understand that a physician may not be present in Bates Health Services during all hours services are furnished to me. At those times when a physician is not present at Health Services there will be a Nurse Practitioner or Registered Nurse available with backup by an on-call physician.

I also grant permission to Bates Health Services, if I cannot be reached or communicated with, to hospitalize and provide any treatment necessary for my son, daughter or ward, or myself [cross out terms not applying], according to professional judgment, if further delay might jeopardize health.

I have read this form, or it has been read to me, and I understand it. I understand that I may have a copy on request.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

BATES COLLEGE REQUIRED PRELIMINARY TB ASSESSMENT

Last Name:_____ First Name: _____ Date of Birth: _____

This section to be completed by the student:

1. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? Yes _____ No _____
2. Were you born or have you lived outside of the USA, Canada, Western Europe, Australia, New Zealand, or Japan? Yes _____ No _____
3. Have you ever received treatment for latent TB? Yes _____ No _____

If Yes was answered to any of the above, the TB Assessment Form must be completed. Every student.

I acknowledge that the above statements are true to the best of my knowledge and belief.

Student Signature:_____ Date:_____

Parent Signature:_____ Date:_____