Student's Name _____

IC ID Number _____

REQUIRED HEALTH FORMS

Please complete this Health Care Certificate and return it to the Chesley Health and Wellness Center before **July 1** for fall semester or **December 1** for spring semester. Permission to register is dependent upon completion of this form. Please call 217.245.3038 if you have questions.

TO RETURN THIS FORM, SCAN AND UPLOAD IT AT LOGIN.IC.EDU IN THE MEDICAT APP.

STUDENT INFORMATION

Student's Name _____ Entry Term (Semester/Year) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Student Cell _____

Date of Birth _____ Social Security Number _____

Sex: ❑ Male ❑ Female ❑ Transgender

Person to notify in case of medical emergency:

Name _____ Relationship _____

Address _____

Home Phone _____ Cell _____ Work _____

If the above number cannot be reached, notify _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Person to notify in case of mental health emergency: ❑ Same as medical emergency contact ❑ I do not want to designate at this time

Name _____ Relationship _____

Address _____

Home Phone _____ Cell _____ Work _____

Do you plan to participate on an athletic team? ❑ Yes ❑ No If so, what sport? _____

SICKLE CELL INFORMATION

What state were you born in? _____ What is your mother's maiden name? _____

What is the name of the birth hospital? _____

INSURANCE INFORMATION – Please include a copy of your insurance card (front and back).

In case of treatment as an outpatient at the hospital or should inpatient hospitalization be required, the bill for care will be sent directly to the student, parent or legal guardian unless the name and policy number of insurance coverage is provided. If your son/daughter is covered by such a policy, please fill in the following and attach a front and back copy of the card:

Name of Insured _____ Social Security Number _____

Insurance Company _____ Group Number _____

ID Number _____ Phone _____

CONSENT FOR TREATMENT OF MINOR STUDENTS

Any person who has reached the age of 18 may, in the State of Illinois, sign his or her own consent for treatment at a hospital or other medical care facility. This is also the case for consenting for counseling and other mental health services. If the student has not reached the age of 18, the following must be signed by the student's parent/guardian for the student to receive treatment.

I, _____hereby give permission for **emergency medical treatment** for

_____should it be necessary before s/he reaches the age of 18.

I, _____hereby give permission for **mental health treatment** for

_____should it be necessary before s/he reaches the age of 18.

HEALTH HISTORY

1. Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergies:
   ❑ Medicines _____ ❑ Pollens _____ ❑ Food _____ ❑ Stinging Insects _____
   ❑ Animals _____ Other: _____

2. If yes, are you receiving allergy shots? ❑ Yes ❑ No

   If yes, will the shots continue while attending college? ❑ Yes ❑ No

3. Give details and dates of all operations and/or hospitalizations (including tonsils and adenoids). ❑ None
   _____
   _____

4. Give details of accidents including dislocations, fractures and any injury with loss of consciousness. ❑ None
   _____
   _____

5. Are you taking any prescription and/or non-prescription medications or supplements (herbal and nutritional)? ❑ Yes ❑ No
   If yes, please list all prescription and non-prescription medications (name, dosage, and frequency): _____
   _____

6. When was your last dental examination?_____
   When was your last eye examination? _____

7. Do you wear glasses/contact lenses? ❑ Yes ❑ No

8. Have you been under the care of a medical specialist during the past year? ❑ Yes ❑ No

   If yes, indicate the reason: _____

   Name, address and phone of specialist _____
   _____

   Dates of Treatment _____

9. Have you been under the care of a mental health specialist (counselor, psychologist, social worker, psychiatrist) during the past year? ❑ Yes ❑ No If yes, indicate the reason: _____

   Name, address and phone of specialist _____
   _____

   Dates of Treatment _____

10. Give age or ages at which you have had any of the following:

- ❑ Anxiety Disorder _____
- ❑ Asthma _____
- ❑ Bipolar Disorder _____
- ❑ Cancer _____
- ❑ Chicken Pox _____
- ❑ Colitis _____
- ❑ COVID-19 (SARS-COV-2) _____
- ❑ Depression _____
- ❑ Diabetes _____
- ❑ Digestive Tract Problem _____
- ❑ Eating Disorder _____
- ❑ Epilepsy/Seizures _____
- ❑ German Measles _____
- ❑ Hay Fever _____
- ❑ Hearing Loss _____
- ❑ Heart Disease/Murmur/ Palpitation _____
- ❑ Hepatitis A, B or C _____
- ❑ Infectious Mononucleosis _____
- ❑ Malaria _____
- ❑ Measles _____
- ❑ Mumps _____
- ❑ Pneumonia _____
- ❑ Post Traumatic Stress Disorder _____
- ❑ Rheumatic Fever _____
- ❑ Rheumatism _____
- ❑ Sickle Cell Trait/Disease _____
- ❑ Skin Disorders _____
- ❑ Strep Throat _____
- ❑ Stomach Ulcer _____
- ❑ Substance Abuse _____
  - ❑ Alcohol _____
  - ❑ Tobacco _____
  - ❑ Other Drugs _____
- ❑ Suicide Attempt _____
- ❑ Thyroid Disease _____
- ❑ Tuberculosis _____
- ❑ Urinary Tract Infection _____

Other diseases (name) _____

11. Any family history of medically unexplained or cardiac cause of death under age 50? ❑ Yes ❑ No
    If yes, please explain: _____

12. Do you have pain or other trouble with your back, legs, feet, hands or joints? ❑ Yes ❑ No
    If yes, please explain: _____

13. Has your weight changed in the past six months? ❑ Yes ❑ No
    Gain or loss? _____How much? _____Why? _____

    Do you have any concerns about food? ❑ Yes ❑ No
    If yes, please explain: _____

CERTIFICATION OF INFORMATION

I certify that the information provided is accurate to the best of my knowledge.

Student Signature _____Date _____

Parent Signature _____Date _____

ILLINOIS COLLEGE

Chelsey Health and Wellness Center
1101 West College Avenue :: Jacksonville, Illinois 62650
217.245.3038 :: Fax 217.245.3039