CONFIDENTIAL

Montgomery County Community College
HEALTH HISTORY/EMERGENCY CONTACT SHEET
340 DeKalb Pike, Blue Bell, PA 19422
www.mc3.edu

To be completed by the STUDENT

MAJOR: (check one) ☐Dental Hygiene ☐Medical Assisting ☐Medical Laboratory Technician ☐Nursing
☐Phlebotomy ☐Radiography ☐Surgical Technology ☐Physical Therapist Assistant

Name: _____
Last *First* *Middle*

Home Address: _____

Date of Birth: _____ **Gender:** _____

Student's Cell Phone #: _____ **MCCC Student ID#** _____

Student's MCCC Email: _____

Student's Personal Email: _____

Please list up to 2 people whom we can contact in cast of emergency: (In order of preference)

Name	Relationship	Work Phone	Cell Phone

Are you allergic to any medications/foods or have you had any bad reactions?

Medication/Food	Type of reaction (e.g., anaphylaxis, lip/tongue swelling, hives, rash, shortness of breath)

List any medication you are currently taking, with dosages:

Please list any major surgeries or hospitalizations you have had:

Surgery/Condition/Hospitalization	Date	Surgery/Condition/Hospitalization	Date

Do you use alcohol? Yes _____ No _____ How often? _____ How much? _____

Have you ever used injection drugs? _____

If you are a former smoker, when did you quit? _____ How long did you smoke? _____ How many packs a day? ____

Have you had traumatic events in your life, either physical or emotional? _____

Name: _____

Have you ever been diagnosed with the following? (Please check all that apply)

	Allergy to latex		High Blood Pressure		Cancer (specify)
	Anemia		High Cholesterol		-
	Anorexia Nervosa		HIV Infection		-
	Anxiety Disorder		Inflammatory bowel disease		Food allergy, serious (specify)
	Arthritis		- Colitis		-
	Asthma		- Crohn's disease		-
	Attention deficit disorder		Learning disability		Hearth/vascular problems
	Bleeding disorder		Loss of consciousness		- Aneurysm
	Blood clots, deep vein		Malaria		- Angina
	Bulimia		Menstrual problems		- Congestive heart failure
	Chicken Pox		Migraine		- Heart Attack
	Chronic fatigue syndrome		Mononucleosis		- Stroke
	Chronic lung disease		Overweight/obesity		Kidney disease
	Concussion		Parasitic disease		STD (specify)
	Depression		Pelvic inflammatory disease		Skin problems, current (specify)
	Diabetes Mellitus		Prostatitis		-
	Eating disorder		Repetitive stress injury		-
	Endometriosis		Seizure		Sleep disorder/insomnia
	Hey fever/allergic rhinitis		Sickle Cell Disease		Thyroid disorder
	Head injury, serious		Smoker		Tuberculosis exposure
	Headaches, severe, non-migraine		Tuberculosis		- treatment:
	Heart murmur		Broken bones, (specify)		Weight gain or loss, recent
	Hepatitis B		-		
	Hepatitis C		-		
			Eye problems, serious (specify)		
			-		

Do You Have A History?	YES	NO
Prosthetic Replacement		
- Joint, Heart Valve		
Infective Endocarditis		
Congenital Heart Condition (specify)		
Organ Transplant		
Have you ever been premedicated with antibiotics for any dental procedures?		

Use this space to provide more details about anything you have checked off above or other health concerns not listed above:

I have reviewed the *Essential Functions and Program Specifications* or *Technical Standards* document specific for my Program major and am capable of meeting the designated criteria. ____ Yes ____ No Comment: _____

Students with disabilities may be eligible for reasonable accommodations. Prior to the start of the Program, please contact the Director of Services for Students with Disabilities in the Disability Services Center in College Hall 225 at (215) 641-6575 for more information. At the West Campus, contact the Coordinator of Disability Services in the Student Success Center at (610) 718-1853.

The statements and answers as recorded above are complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my education.

_____ _____

Student's Signature *Date*

Originated: 6/2018