RAMAPO COLLEGE OF NEW JERSEY

CENTER FOR INNOVATIVE AND PROFESSIONAL LEARNING
505 Ramapo Valley Road, Mahwah, NJ 07430-1680
Phone (201) 684-7370 Fax (201) 684-7277
www.ramapo.edu/ramapocamps

HEALTH HISTORY FORM FOR RAMAPO COLLEGE PROGRAMS, CAMPS, SPECIAL EVENTS AND CONFERENCES

The information on this form is not part of the participant's acceptance process but is gathered to assist Health Services in identifying appropriate care. Any changes to this form should be provided upon participant's arrival. Please provide complete information so that the Ramapo College of NJ Health Services Department can be aware of your needs.

Name: _____ Birth Date _____
Last First Middle

Home Address _____
Street Address City State Zip

Social Security Number of Participant _____ Gender ☐ Female ☐ Male

CIPL Program: ☐ FINANCIAL LIT/STOCK MARKET ☐ RAMAPO EXPLORERS-STEM ☐ RAMAPO EXPLORERS-THEATER

☐ GAME DESIGN FOR TEENS ☐ PROGRAMMING/DATA SCIENCE CAMP ☐ OTHER (write in below)

Write in OTHER _____

Custodial Parent / Guardian _____ Phone _____

Home Address _____
If different from above Street Address City State Zip

Business Address _____ Phone _____
Street Address City State

Second Parent / Guardian or Emergency Contact _____

Address _____ Phone _____
Street Address City State

Business Address _____ Phone _____
Street Address City State

If not available in an emergency, notify:_____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical /hospital insurance? ☐ YES ☐ NO

If YES, indicate carrier or plan name _____ Group # _____

- **Photocopy of front and back of insurance card must be attached to this form.**

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IMPORTANT –THIS SECTION MUST BE COMPLETED

Parent / Guardian Authorization: This health history is correct and complete as far as I know and the Person herein Described has permission to engage in all activities except as noted.

I hereby give permission to Ramapo College of NJ, Health Services Department, to provide routine health care, prescribe medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Ramapo College of NJ, Health Services Department, to secure and administer treatment. In the event of transportation to a local hospital, I give permission for the transportation, the release of medical records and information to the hospital. I hereby give permission for the photocopy of this form for use in those situations.

Signature of parent / guardian _____ Date _____

Printed Name _____

Allergies *Please list all known. Attach additional sheets as necessary.*

Medication Allergies (list) Please describe reaction and usual management for the reaction

_____ _____

_____ _____

Food Allergies (list) Please describe reaction and usual management for the reaction

_____ _____

_____ _____

Other Allergies (list) Please describe reaction and usual management for the reaction. Please include insect stings, hay fever, animal, etc.

_____ _____

_____ _____

Medication Currently Being Taken Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring enough medication to last while you are at Ramapo College of NJ. Please keep medications in original packaging / bottle that identifies the prescribing medical provider (for prescription drugs), as well as the name of the medication, the dosage, and the frequency of administration.

Attach additional pages as needed.

☐ This person **takes NO medications** on a routine basis.
☐ This person **takes medications** as follows:

Medication #1 _____ Dosage _____

Specific times when medication is taken each day _____

Reason for taking medication _____

Medication #2 _____ Dosage _____

Specific times when medication is taken each day _____

Reason for taking medication _____

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Restrictions The following restrictions apply to this individual

Does not eat ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry
☐ Seafood ☐ Eggs ☐ Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary.)
_____
_____

General Information Please explain all "YES" answers below

Has the participant:	YES	NO
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness / condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had a back problem?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Ever had skin problems (e.g., itching, rash, acne, hives)?	☐	☐
19. Have diabetes?	☐	☐
20. Have asthma?	☐	☐
21. Had mononucleosis in the past 12 months?	☐	☐
22. Had problems with diarrhea or constipation?	☐	☐
23. If female, an abnormal menstrual cycle?	☐	☐
24. Ever had an eating disorder?	☐	☐
25. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "YES" answers, noting the number for each question before the response

_____
_____
_____

Please use this area to provide any additional information about the participant's behavior, emotional, physical or mental health about which Health Services should be aware.

_____
_____
_____
_____
_____

Name of Family Health Care Provider / Physician _____

Address _____ Phone _____
Street Address *City* *State* *Zip*