Oakton College

Health Services

1600 E. Golf Rd., Des Plaines, IL 60016, 847.635.1885, Fax 847.376.7010
7701 N. Lincoln Ave., Skokie, IL 60077, 847.635.1419, Fax 847.376.7650

Confidential Medical History and Authorization for Release of Education Records

To be completed by student and returned to Health Services, with a signed physician statement and copies of the student's immunization record and TB test or chest x-ray results attached. Please print.

Program ______________________ **Date program starts** ______________

Last name ______________ First ______________ M.I. _____ (Maiden) ______________

Date of Birth ______________________ Phone ______________________

Address ______________________ City ____________ State ________ Zip ________

Person to notify in an emergency: Phone ______________ Relationship ______________

Have you ever had any serious injuries, major illnesses or operations? ❑ No ❑ Yes If yes, give details: __________

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Have you ever had			**Do you now have**		
Rubella (German Measles)	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Rubeola	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Epilepsy (seizures)	❑ Yes	❑ No	Colitis	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No

Are there any other conditions of which Health Service should be aware? ❑ No ❑ Yes

If yes, please explain: ____

Can you perform all the functions required of a student assigned to a participating health care setting at an affiliating institution with or without accommodation? ❑No ❑Yes If you require accommodation, please explain:

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Are there any foods or medications you are allergic to? ❑ No ❑Yes If yes, give details: ______________

Authorization for Release of Education Records to Affiliated Clinical Agencies

I give my permission for the Health Services Department at Oakton College to release a copy of this Confidential Medical History, and any and all supporting documentation reflecting my compliance with clinical health requirements, to appropriate representatives of the clinical agencies affiliated with the program in which I am enrolled. The purpose of this release of information is to verify my compliance with clinical health requirements.

This authorization is valid for 12 months unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the College or the designated individual/agency in reliance upon my authorization and prior to notice of my revocation. I recognize that health records, once received by the College, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act ("FERPA"). I understand that I have a right to inspect and review my education records and to challenge their contents.

I understand that withholding information or giving false information about my compliance with clinical placement health requirements may result in my dismissal from the program.

Signature ______________________________________ Date ______________

Students will not be able to attend the clinical portion of the program without receiving a medical clearance from Health Services. Clinical sites reserve the right to change health requirements at any time based on current medical practices.