Health History and Immunization Record

All new students are REQUIRED to submit a completed Health History and Immunization Record before class registration.

NAME ____

ADDRESS ____
Street

____
City State Zip Country

CELL PHONE (______) ______________________ DATE OF BIRTH ______________________
Day Month Year

EMERGENCY CONTACT INFORMATION (state relationship) ______________________

NAME ____

ADDRESS ____
Street

____
City State Zip Country

____
HOME PHONE CELL PHONE WORK PHONE

MEDICAL HISTORY Do you have a past or present history of the following? Check all that apply

___ Alcohol abuse	___ Drug abuse	___ Intestinal/stomach trouble	___ Rubella
___ Anemia	___ Ear trouble	___ Joint disease	___ Scarlet fever
___ Arthritis	___ Eating disorder	___ Measles, Red	___ Joint disease
___ Asthma	___ Eye disease	___ Menstrual problems	___ Sexually Transmitted Disease
___ Back problems	___ Gallbladder trouble	___ Migraine headaches	___ Sickle Cell Trait/Anemia
___ Cancer	___ Hay fever	___ Mononucleosis	___ Sinus trouble
___ Colitis	___ Head injury	___ Mumps	___ Smoking (how long)
___ Convulsions/Seizures	___ Headache	___ Pneumonia	______________
___ Cough	___ Heart disease	___ Paralysis	___ Spleen, surgical removal
___ Depression	___ Hepatitis/jaundice	___ Polio	___ Thyroid disease
___ Diabetes	___ Hernia/rupture	___ Psychological consult	___ Tuberculosis
___ Disability/Handicap	___ High blood pressure	___ Rheumatic fever	___ Urinary tract infections

___ Other ____

Brief explanation of any marked above ______________________________

____

Medications ____

Drug allergies ____

Other allergies (animals, seasonal, food, etc.) ______________________________

Hospitalizations and/or surgeries ______________________________

FAMILY HISTORY Place relationship in blank. Check all that apply

- o Alcohol/drug abuse ______________________
- o Bleeding disorder ______________________
- o Cancer/type ______________________
- o Death before age 50 ______________________
- o Diabetes ______________________
- o Elevated cholesterol ______________________
- o Heart disease ______________________
- o Hypertension/stroke ______________________
- o Mental illness ______________________
- o Thyroid problem ______________________

Required Immunizations and Tests

ALL STUDENTS - Please provide dates for all of the following:

DATE RECEIVED:

MMR (Measles, Mumps, Rubella) Two doses are required
#1 ______________________
#2 ______________________

OR date of blood titer test and results ______________________

MCV4 (Meningococcal Meningitis Vaccine)
#1 ______________________

OR sign waiver (see Statement of Exemption below)
#2 ______________________

Tdap (Tetanus/Diphtheria/Acellular Pertussis) ______________________
(within past 10 years)

Varicella (Chicken Pox) must provide one of the following:

Two varicella vaccinations at least 4 weeks apart:
#1 ______________________
#2 ______________________

OR Documented proof of immunity with date of infection: ______________________

INTERNATIONAL STUDENTS - Additional requirement before enrollment – no exemption allowed:

Tuberculin (Mantoux only) skin test only within past year in U.S.

Date and Results: ______________________

Chest X-ray (only if known positive skin test) Results: ______________________

RECOMMENDED IMMUNIZATIONS AND TESTS

IPV (Polio) Date of last dose ______________________

HPV2 or HPV4 – Series of three
#1 ______________________
#2 ______________________
#3 ______________________

Hepatitis B – Series of three
#1 ______________________
#2 ______________________
#3 ______________________

STATEMENT OF EXEMPTION (For personal or religious beliefs or specific medical condition)

In the event of an outbreak, exempted persons will be subject to exclusion from campus.

MEDICAL EXEMPTION: The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated because of other medical conditions.

Medical professional's signature ______________________

Work telephone (______) ______________________ Date ______________________

PERSONAL OR RELIGIOUS EXEMPTION: Parent or guardian of the above-named person or the person himself/herself adheres to a personal belief opposed to immunizations.

____

Signature of Parent, Legal Guardian, Emancipated student/Consenting minor Date

REQUIRED VERIFICATIONS

STUDENTS UNDER AGE 18: I grant permission to the medical staff at the Student Health Center, William Jewell College, to treat my son/daughter as may be necessary, and if needed, to refer to private care when special service is indicated.

Parent/legal guardian signature______________________ Date ______________

STUDENTS 18 AND OLDER: By signature, I verify that information provided on the form is true, and I give permission for such diagnoses, tests and therapeutic procedures, as may be deemed necessary for me.

Student signature______________________ Date ______________

______________________ ______________________ ______________

Physician's Printed Name Physician's Signature Date