WILLIAM JEWELL COLLEGE

Health History and Immunization Record

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

NAME_____

ADDRESS_____

CELL PHONE (_____) _____ DATE OF BIRTH _____

Month Day Year

EMERGENCY CONTACT INFORMATION (state relationship)_____

NAME_____

ADDRESS_____

_____

HOME PHONE CELL PHONE WORK PHONE

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

Alcohol abuse	Diabetes (require insulin Y/N)	Menstrual problems
ADD/ ADHD	Disability	Mononucleosis
Allergies	Drug Abuse	Paralysis
Anemia	Ear problems	Pneumonia
Anxiety	Eating disorder	Seizure disorder
Arthritis	Eye problems	Sickle cell anemia
Asthma	Headaches	Skin problems /infections
Back problems	Head injury	Smoking (how long _____)
Blood clot	Heart disease / problems	Stomach problems
Cancer	High blood pressure	Thyroid problems
Colitis	Intestinal problems	Tuberculosis
Depression	Joint disease	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 *Circle all that apply and indicate relationship*

Alcohol / Drug abuse: _____ Diabetes: _____

Bleeding disorder: _____ Heart Disease/ hypertension: _____

Cancer/ type: _____ Mental Illness: _____

Death before age 50: _____ Other familial health problems: _____

Required Immunizations and Tests

ALL STUDENTS – Please provide dates and documentation for all of the following:
NURSING MAJORS – Clinical agencies require all of these and other additional immunizations. Speak with the Department of Nursing if you have any questions.

COVID 19 – Manufacturer_____
#1_____ **#2**_____
Booster Date/Manufacturer_____ /_____

MMR (Measles, Mumps, and Rubella) two doses are required – please provide dates:
#1 _____ #2 _____ or blood titer results: _____

MCV (Meningitis vaccine): One dose must be after age 16. If initial dose after age 16, only one dose required
#1 _____ #2 _____

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

Varicella (Chicken pox) two vaccinations at least 4 weeks apart or proof of immunity (titer / blood test) or health care provider documented date of infection:
#1 _____ #2 _____

INTERNATIONAL STUDENTS - Additional requirement before enrollment – no exemption allowed:
Tuberculin skin test within the last year in the United States:
Date and Results: _____
Quantiferon Gold results: (optional, in lieu of skin testing) _____
Chest X-ray (only if known positive skin test) Results: _____

RECOMMENDED IMMUNIZATIONS

Meningitis B vaccine 2 doses at least one month apart #1 _____

#2 _____

IPV (Polio) Date of last dose _____

HPV (series of 2 or 3, depending on age started)
#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 or herself adheres to a personal belief opposed to immunization.

_____
Signature of Student over 18 years of age, or parent, Legal Guardian, Emancipated student/Consenting minor

Date_____

REQUIRED VERIFICATIONS

STUDENTS UNDER AGE 18: I grant permission to the 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 _____

Health Care Provider Verification (required if official record on agency letterhead or card not provided)

_____	_____	_____
Health Care provider's Printed Name	Provider's Signature	Date