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 required vaccinations:
NURSING MAJORS - Clinical agencies require all of these and other additional immunizations. Speak with the Department of Nursing if you have any questions.

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 _____

The COVID-19 vaccine is no longer required. We recommend that all students follow the CDC guidelines surrounding the COVID-19 vaccine.

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 within the past year: (optional, in lieu of skin testing) _____
Chest X-ray (only if known positive skin test) Results within the past year: _____

RECOMMENDED IMMUNIZATIONS

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

#2 _____
IPV (Polio) Date of last dose _____

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
Please list vaccines you are requesting exemption from:

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 vaccination record on agency letterhead or card not provided)

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