HEALTH HISTORY AND IMMUNIZATION RECORD

❑ Male
❑ Female

STUDENT NAME ____________ DATE OF BIRTH (MONTH, DAY, YEAR) ____________

PERMANENT ADDRESS ____________ STATE ______ ZIP ______ COUNTRY ______

( ) ____________ PERMANENT TELEPHONE

( ) ____________ CELL PHONE

EMERGENCY CONTACT INFORMATION

NAME ____________

ADDRESS ____________

( ) ____________ HOME PHONE

( ) ____________ WORK PHONE

CONFIDENTIAL MEDICAL HISTORY

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

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

____ 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*

❑ Alcohol/drug abuse____________
❑ Bleeding disorder ____________
❑ Cancer/type: ________ ____________
❑ Death before age 50____________
❑ Diabetes____________
❑ Elevated cholesterol ____________
❑ Heart disease ____________
❑ Hypertension/stroke ____________
❑ Mental illness ____________
❑ Thyroid problem____________

RETURN COMPLETED FORM TO:
William Jewell College
Student Health Center, WJC Box 1027
500 College Hill
Liberty, MO 64068

REQUIRED IMMUNIZATIONS AND TESTS

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 ______

- **MMV (Meningococcal Meningitis Vaccine)** ______

  OR sign waiver (see Statement of Exemption below)

ALSO REQUIRED FOR ALL INTERNATIONAL STUDENTS BEFORE ENROLLMENT – NO EXEMPTION ALLOWED:

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

  Results: ______

- **Chest X-Ray** (only if known positive skin test) ______

  Results: ______

RECOMMENDED IMMUNIZATIONS

DATE RECEIVED:

- Tetanus/Diptheria Booster (within the past 10 years) ______
- Polio (give date of last dose) ______
- Hepatitis B — #1 ______ #2 ______ #3 ______
- Varicella (Chicken Pox) – not needed if history of natural infection — #1 ______ #2 ______

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

CONSENT FOR TREATMENT

STUDENTS UNDER AGE 18: I grant permission to William Jewell College to seek treatment for 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 ______

FOR ALL STUDENTS: By my signature, I verify that the information provided on this form is true, and I give permission for such diagnosis, tests and therapeutic procedures, as may be deemed necessary for me.

______ ______ ______
Student printed name — Student signature — Date