

# HEALTH HISTORY AND IMMUNIZATION RECORD

## BEGINNING THE JEWELL JOURNEY

STUDENT NAME \_\_\_\_\_  Male  Female \_\_\_\_\_ 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*

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

- |                                                    |                                                     |
|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Alcohol/drug abuse _____  | <input type="checkbox"/> Elevated cholesterol _____ |
| <input type="checkbox"/> Bleeding disorder _____   | <input type="checkbox"/> Heart disease _____        |
| <input type="checkbox"/> Cancer/type: _____        | <input type="checkbox"/> Hypertension/stroke _____  |
| <input type="checkbox"/> Death before age 50 _____ | <input type="checkbox"/> Mental illness _____       |
| <input type="checkbox"/> Diabetes _____            | <input type="checkbox"/> Thyroid problem _____      |

# REQUIRED IMMUNIZATIONS AND TESTS

## BEGINNING THE JEWELL JOURNEY

### PLEASE PROVIDE DATES FOR ALL OF THE FOLLOWING

- **MMR (Measles, Mumps, Rubella)** Two doses are required

OR date of blood titer test and results

- **MMV (Meningococcal Meningitis Vaccine)**

OR sign waiver (see Statement of Exemption below)

### DATE RECEIVED:

#1 \_\_\_\_\_

#2 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

- Tetanus/Diphtheria Booster (within the past 10 years)

- Polio (give date of last dose)

- Hepatitis B

- Varicella (Chicken Pox) - not needed if history of natural infection

### DATE RECEIVED:

\_\_\_\_\_

\_\_\_\_\_

#1 \_\_\_\_\_

#2 \_\_\_\_\_

#3 \_\_\_\_\_

#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 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 \_\_\_\_\_

**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