



WILLIAM JEWELL COLLEGE
Health History and Immunization Record

Name _____

Address _____
 Street

City State Zip Country

Telephone (_____) Date of Birth _____
 Area Code Day Month Year

Emergency Contact Person (state relationship) _____

Name _____

Address _____
 Street

City State Zip Country

Home Telephone (_____) Work Telephone (_____) _____
 Area Code Area Code

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"/> Sleep problems |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Headache | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Smoking (how long) _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Spleen, surgical removal |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia/rupture | <input type="checkbox"/> Psychological consult | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Disability/Handicap | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> 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 *Check all that apply.* (Place relationship in blank.)

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

Please 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.

Please provide dates below:

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 the past year in the United States

Results: _____

Chest X-Ray (only if known positive skin test) _____
Results: _____

RECOMMENDED IMMUNIZATIONS

Please provide dates below:

Tetanus/Diphtheria 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.

Parent, Legal Guardian, Emancipated student/Consenting minor Signature _____
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 signature, I verify that that information provided on the form is true, and I give permission for such diagnosis, tests and therapeutic procedures, as may be deemed necessary for me.

Student Signature _____ Date _____