

# HEALTH HISTORY AND IMMUNIZATION RECORD

## BEGINNING THE JEWELL JOURNEY

STUDENT NAME \_\_\_\_\_

Male  Female

PERMANENT ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COUNTRY \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_

PERMANENT TELEPHONE \_\_\_\_\_

DATE OF BIRTH (DAY, MONTH, YEAR) \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_

### 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

### 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/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.

\_\_\_\_\_  
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 signature \_\_\_\_\_ Date \_\_\_\_\_