Health History and Immunization Record

BEGINNING THE JEWELL JOURNEY

All new students are ***REQUIRED*** to submit a completed Health History and Immunization Record before class registration.

NAME _____

ADDRESS _____
Street

_____
City State Zip Country

CELL PHONE (_____) _____ DATE OF BIRTH _____
Day Month Year

EMERGENCY CONTACT INFORMATION (state relationship) _____

NAME _____

ADDRESS _____
Street

_____
City State Zip Country

_____
HOME PHONE CELL PHONE WORK PHONE

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
___ Gallbladder 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
___ Joint disease
___ Sexually Transmitted Disease
___ Sickle Cell Trait/Anemia
___ Sinus trouble
___ Smoking (how long)
_____
___ Spleen, surgical removal
___ Thyroid disease
___ Tuberculosis
___ 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 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 _____

Required Immunizations and Tests

BEGINNING THE JEWELL JOURNEY

ALL STUDENTS - 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* _____

MCV4 (Meningococcal Meningitis Vaccine) #1 _____
OR sign waiver (see Statement of Exemption below) #2 _____

Tdap (Tetanus/Diphtheria/Acellular Pertussis) _____
(within past 10 years)

Varicella (Chicken Pox) *must provide one of the following:*
Two varicella vaccinations at least 4 weeks apart: #1 _____
#2 _____

OR Documented proof of immunity with date of infection: _____

INTERNATIONAL STUDENTS - Additional requirement before enrollment – no exemption allowed:
Tuberculin (Mantoux only) skin test only within past year in U.S.
Date and Results: _____
Chest X-ray (only if known positive skin test) Results: _____

RECOMMENDED IMMUNIZATIONS AND TESTS
IPV (Polio) Date of last dose _____
HPV2 or HPV4 – Series of three #1 _____
#2 _____
#3 _____

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.

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

REQUIRED VERIFICATIONS
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 _____
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 _____

PHYSICIAN VERIFICATION

_____ _____ _____
Physician's Printed Name Physician's Signature Date