



Health History and Immunization Record

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

NAME _____

ADDRESS _____

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

EMERGENCY CONTACT INFORMATION (state relationship) _____

NAME _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

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

- | | | |
|---------------|--------------------------------|--------------------------|
| Alcohol abuse | Diabetes (require insulin Y/N) | Menstrual problems |
| ADD/ADHD | Disability | Mononucleosis |
| Allergies | Drug Abuse | Paralysis |
| Anemia | Ear problems | Pneumonia |
| Anxiety | Eating disorder | Seizure disorder |
| Arthritis | Eye problems | Sickle cell anemia |
| Asthma | Headaches | Skin problems/infections |
| Back problems | Head injury | Smoking (how long _____) |
| Blood clot | Heart disease/problems | Stomach problems |
| Cancer | High blood pressure | Thyroid problems |
| Colitis | Intestinal problems | Tuberculosis |
| Depression | Joint disease | 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 *Circle all that apply and indicate relationship*

Alcohol/Drug abuse: _____ Diabetes: _____

Bleeding disorder: _____ Heart Disease/hypertension: _____

Cancer/type: _____ Mental Illness: _____

Death before age 50: _____ Other familial health problems: _____



Required Immunizations and Tests

ALL STUDENTS - Please provide dates and documentation for all of the following:

MMR (Measles, Mumps, and Rubella) two doses are required – please provide dates:

#1 _____ #2 _____ or blood titer results: _____

MCV (Meningitis vaccine): One dose must be after age 16. If initial dose after age 16, only one dose required

#1 _____ #2 _____

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

Varicella (Chicken pox) two vaccinations at least 4 weeks apart or proof of immunity (titer / blood test) or health care provider documented date of infection:

#1 _____ #2 _____

INTERNATIONAL STUDENTS - Additional requirement before enrollment - no exemption allowed:

Tuberculin skin test within the last year in the United States:

Date and Results: _____

Quantiferon Gold results: (optional, in lieu of skin testing) _____

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

RECOMMENDED IMMUNIZATIONS

Meningitis B vaccine 2 doses at least one month apart

#1 _____

#2 _____

IPV (Polio)

Date of last dose _____

HPV (series of 2 or 3, depending on age started)

#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 or herself adheres to a personal belief opposed to immunization.

Signature of Student over 18 years of age, or parent, Legal Guardian, Emancipated student/Consenting minor

Date _____

REQUIRED VERIFICATIONS

STUDENTS UNDER AGE 18: I grant permission to the 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 _____

Health Care Provider Verification (required if official record on agency letterhead or card not provided)

Health Care provider's Printed Name

Provider's Signature

Date