HEALTH HISTORY AND IMMUNIZATION FORM

EVANGEL UNIVERSITY HEALTH SERVICES

1111 N. Glenstone, Springfield, MO 65802 (417) 865-2815, ext. 7280 Fax (417) 575-5496

All undergraduate students who are enrolled in 6 credit hours or more must complete this form. Official documentation of your immunization dates must be attached. **Student athletes must complete this form in addition to the physical exam obtained for the athletic department.** Students whose health information is not complete will not be officially enrolled in the University.

Please TYPE or PRINT your information. The contents of this record are confidential and cannot be released without your permission.

NAME: _____ Social Security # _____/_____/_____
Last First Middle

HOME ADDRESS: _____
Street, Box or Route City State Zip Code

AGE: ____ BIRTHDATE: ____/____/____ SEX: ____ HOME PHONE: _____

EXPECTED 1ST SEMESTER: _____ CELL PHONE: _____
Examples: Fall 2016, Spring 2017

COUNTRY OF CITIZENSHIP (if international student): _____

IMMUNIZATION HISTORY – Please enter dates in month, date, year format (mm/dd/yy). **Official documentation of your immunization records must also be attached.** These can include copies of medical records, school records, official signed immunization cards, and insurance receipts. **Your immunizations will not be considered valid and will not be entered into the computer system without official documentation.**

REQUIRED IMMUNIZATIONS:

- **Tetanus-Diphtheria Booster _____ (must be given within the past 10 years)**
  (May be listed on immunization records as: Td, Td-B, DT, DPT, Tdap, Adacel, or Boostrix)
- **Two doses of MMR (Measles, Mumps & Rubella) Vaccine**
  Dose #1 _____ (must be given after the first birthday)
  Dose #2 _____ (must be given at least 30 days after dose #1)

RECOMMENDED IMMUNIZATIONS—Not required, but strongly encouraged. Having records of these dates on file would be beneficial to students who plan to participate in overseas mission trips.

- Hepatitis A (two doses): #1 _____ #2 _____
- Hepatitis B (three doses): #1 _____ #2 _____ #3_____
- Meningococcal/Meningitis _____ Circle type if known: Menactra (MCV4) or Menomune (MPSV4)
- Varicella/Chicken Pox (two doses): #1 _____ #2 _____

OTHER IMMUNIZATIONS THAT YOU MAY HAVE RECEIVED IN PREPARATION FOR OVERSEAS TRAVEL:

- Adult Polio Booster _____
- Typhoid _____ Circle type: Oral or Injectable
- Yellow Fever _____

CONSENT FOR TREATMENT

Consent is hereby given for treatment in the Evangel University Student Health Center by duly licensed medical personnel or by a Health Care Provider of choice in the community for routine health care, assessment, diagnosis, treatment and if necessary hospitalization. It is understood that the university will contact the next of kin as soon as possible in the case of emergency or serious illness.

Signature (student) _____ Date _____

Parent or guardian must also sign if the student is under 18 years of age at the time this medical information is submitted.

Signature (Parent or guardian) _____ Date _____

Home Phone _____ Cell Phone _____

PERSONAL HEALTH HISTORY **NAME** _____

Do you have a health condition that may require special assistance while you are at Evangel? _____ If yes, please specify _____

Are you under the care of a healthcare provider at present? ____ If yes, please specify _____

List medications taken on a daily basis. _____

Allergies? (Medication, Food, Plants, Insect bite, Other) _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Neurological	**Yes**	**No**
Convulsions or seizures		
Dizziness		
Fainting spells		
Frequent or severe headaches		
Numbness or tingling in arms or legs		
Other		

Eyes, Ears Nose and Throat	**Yes**	**No**
Persistent pain in eyes		
Persistent watering or itching of eyes		
Visual problem affecting ability to see clearly		
Frequent earaches		
Hearing loss		
Frequent runny/stuffy nose		
Sinusitis		
Tonsillitis		
Persistent/frequent hoarseness		
Frequent toothache or sore bleeding gums		
Other		

Glandular and Blood	**Yes**	**No**
Anemia		
Diabetes *		
Enlarged glands		
Thyroid disease		
Unexplained bruising or bleeding		
Other		

Cardiovascular	**Yes**	**No**
Frequent or severe chest pain		
Heart murmur		
High blood pressure		
Irregular or very rapid heart heat		
Rheumatic fever		
Undue shortness of breath		
Other		

Respiratory	**Yes**	**No**
Allergy injections *		
Asthma		
Chronic cough or bronchitis		
Frequent or persistent wheezing		
Positive TB skin test		

Digestive	**Yes**	**No**
Unexplained weight loss or gain		
Frequent nausea, vomiting or diarrhea		
Change in bowel habits		
Black tarry stools		
Frequent constipation		
Liver disease or jaundice		
Gallbladder disease or gallstones		
Peptic ulcer		
Other		

Urinary	**Yes**	**No**
Blood or pus in urine		
Kidney disease or kidney stones		
Painful, frequent or difficult urination		
Nodule in testicle (men only)		
Other		

Menstrual (women only)	**Yes**	**No**
Excessive flow or clots		
Irregular periods		
Severe menstrual cramping		
Other		

Musculoskeletal and Skin	**Yes**	**No**
Acne		
Arthritis		
Back pain		
Joint pain		
Neck pain		
Skin rash		
Other		

Emotional	**Yes**	**No**
Anorexia or bulimia		
Depression or excessive sadness		
Excessive worry or nervousness		
Feeling lonely or left out		
Suicidal thoughts or attempt		
Other		

Substance Abuse	**Yes**	**No**
Alcoholism		
Drug Abuse		

If you answered yes to any of the above questions or have other health problems not covered by this questionnaire, please explain in greater detail (use an additional sheet of paper if necessary) _____

_____

_____

* Diabetic patients or students that use any injectable medications need to obtain proper needle disposal equipment from the Wellness Center.
* Allergy injections must be given by health care personnel in the Wellness Center.