

To be completed by student

Allergies (Food/Meds) _____ Weight _____ Height _____

List medicine(s) currently taking _____

Please rate your physical health (as of 90 days) Good _____ Fair _____ Poor _____

Check any medical problem(s) listed below that you have or have had:

Alcoholism _____	Gallbladder Disease _____
Arthritis _____	Gastric reflux _____
Anorexia Nervosa _____	Hay fever _____
Asthma _____	Hearing disorder (right/left) _____
Back pain _____	Heart disease _____
Bipolar Disorder _____	Hepatitis _____
Bladder infection _____	High blood pressure _____
Blindness _____	Kidney problem _____
Bronchitis _____	Low back pain _____
Bulimia _____	Meningitis _____
Cerebral palsy _____	Mitral valve prolapse _____
Chronic pain (Specify) _____	Multiple sclerosis _____
Colitis _____	Obesity _____
Deafness _____	Paralysis _____
Depression _____	Peptic ulcer _____
Diabetes _____	Pneumonia _____
Drug/substance abuse _____	Pregnancy (how many months) _____
Dysmenorrhea _____	Sickle cell anemia _____
Effects from injury _____	Stress _____
Epilepsy _____	Stroke _____
Fibrocystic disease _____	Tuberculosis _____

Other specify _____

Do you have a permanent physical or mental disability? _____ Yes _____ No

Specify _____

Does the disability require assistive devices, handicap parking, etc? _____ Yes _____ No

Please specify _____

Do you wear glasses / contact lenses? _____ Yes _____ No Do you smoke cigarettes? _____ Yes _____ No, If so how many cigarettes per day? _____ or Packs per day _____

List any surgeries: _____

Student's Signature: _____ Date: ____/____/____

If student is a minor, parent or guardian's signature: _____

REQUIRED IMMUNIZATION

(Type or Print in blue or black ink only)

Name _____ Student ID# _____ DOB ____/____/____
Last First Middle

T.B. SKIN TEST (MANTOUX): NEEDS TO BE DONE WITHIN SIX MONTHS OF REGISTRATION.
TINE TEST IS NOT ACCEPTED: SKIN TEST REQUIRED, REGARDLESS OF PRIOR BCG INOCULATIONS.

Date applied ____/____/____ Site of injection _____ Lot # _____ Manufacturer _____

Date read ____/____/____ Results (mm) _____ (Copy of Chest X-rays required if TB test is Positive)

HISTORY OF POSITIVE TB SKIN TEST: Complete TB interview or have M.D. send a statement documenting health status – no communicable disease.

Health Care Provider's Signature and Official Stamp _____

TETANUS (DPT/TD/DT) REQUIRED TO HAVE BEEN DONE WITHIN THE PAST TEN YEARS

Date ____/____/____ Lot# _____ Manufacturer _____

Health Care Provider's Signature and Official Stamp _____

***** IF BORN PRIOR TO 1957, MEASLES VACCINE IS NOT REQUIRED *****
(MEASLES DOSE #1 – 12-15 MONTHS AFTER BIRTH, DOSE #2 – AFTER 1980)

MMR #1 DOSE ____/____/____ MMR #2 DOSE ____/____/____
OR

MEASLES (RUBEOLA)

1ST Dose ____/____/____ Mumps Dose ____/____/____ Rubella Dose ____/____/____

2ND Dose ____/____/____

OR

OR

OR

SEROLOGIC TEST

SEROLOGIC TEST

SEROLOGIC TEST

(Attach copy of lab results for serologic test)

RESULTS _____

RESULTS _____

RESULTS _____

MENINGOCOCCAL MENINGITIS Date ____/____/____ (Provide proof if immunized in past 3yrs.)

Health Care Provider's Signature & Official Stamp _____ Date ____/____/____

SUGGESTED IMMUNIZATIONS, NOT REQUIRED, INDICATE DOCUMENTATION

HEPATITIS B:

1. Document Completed #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ or Titer Results _____
mo/yr mo/yr mo/yr

2. Varicella (Chicken Pox) Vaccinated #1 ____/____/____ #2 ____/____/____ or Titer Results _____
mo/yr mo/yr

Health Care Provider's Signature & Official Stamp _____ Date ____/____/____

