

# BAKER

## For the (health) record

Please complete your health history form and return to:

Student Health Center  
P.O. Box 65  
Baldwin City, Kansas 66006  
785.594.8409

Please include:

- COPY OF IMMUNIZATION RECORD
- COPY OF INSURANCE CARD

To provide an environment in which student health is maintained, it is essential to have the information requested.

## Tell us about yourself

Name: *Please print.*

\_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Cell Phone # of student (\_\_\_\_) \_\_\_\_\_

SSN# \_\_\_\_\_

Date of Entrance \_\_\_\_\_

Gender:  Female  Male

Marital Status:

Single  Married  Widowed  Divorced

Father's/Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_

(if different from above)

Father's/Spouse's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Mother's/Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_

(if different from above)

Mother's/Spouse's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Person to Call in an Emergency \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

## Tell us about your family's health history

Relation	Age	State of health			If deceased, cause of death	Age at death
		good	fair	poor		
Father		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Mother		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Brothers		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Sisters		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

Has any parent, brother, or sister had:

**YES NO** if "yes" to any, please explain:

Asthma/hay fever   \_\_\_\_\_

Cancer   \_\_\_\_\_

Diabetes   \_\_\_\_\_

Heart trouble   \_\_\_\_\_

Convulsive disorder   \_\_\_\_\_

Alcoholism   \_\_\_\_\_

Hypertension   \_\_\_\_\_

Tuberculosis   \_\_\_\_\_

## Insurance Information (Please attach a copy of Insurance Card)

Company \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_

ID# \_\_\_\_\_

Group # \_\_\_\_\_

Policy Holders SSN # \_\_\_\_\_

Traditional Plan  PPO  HMO  Other

Physician's Name \_\_\_\_\_

Phone \_\_\_\_\_

Do you plan to participate in varsity sports?  Yes  No

Sport: \_\_\_\_\_

International students are required to purchase their health insurance policy through Baker University when they enroll in classes.

PLEASE COMPLETE BOTH SIDES OF THIS FORM.



**BAKER**  
UNIVERSITY

1858

*Own Confidence*

STUDENT HEALTH CENTER  
P.O. Box 65  
Baldwin City, KS 66006-0065

785.594.8409

## Have you had...?

### Yes No **ACUTE INFECTIOUS DISEASES**

- Chicken Pox
- Hepatitis
- Infectious Mononucleosis (mono)
- Pneumonia
- Tonsillitis
- Typhoid
- Sexually Transmitted Diseases
- Measles
- Mumps
- Other \_\_\_\_\_

### Yes No **OTHER DISEASES**

- Alcoholism/Drug Addiction
- Anemia
- Anorexia/Bulimia
- Asthma
- Cancer
- Chronic Bronchitis
- Chronic Skin Disease (eczema, psoriasis)
- Convulsions, Seizures (epilepsy)
- Dental Problems
- Diabetes
- Digestive Tract Disease (ulcer, colitis)
- Gallbladder/Liver Disease
- Glaucoma
- Hay Fever
- Heart Disease (rheumatic fever, murmur)
- High Blood Pressure
- Kidney or Bladder Disease
- Malaria
- Orthopedic Problems (knee, back)
- Prolonged Depression or Anxiety
- Speech, Hearing, Vision Problems
- Severe Headache (migraine)
- Thrombophlebitis
- Thyroid or Endocrine Disturbance
- Tuberculosis
- Other: \_\_\_\_\_

### Yes No **OTHER HEALTH CARE HISTORY**

- Have you ever been hospitalized?
- Have you had any surgical operations?
- Are you under medical treatment?
- Do you take any prescribed medicine or injection?
- Do you have a physical handicap?
- Do you need any special arrangements?
- Have you been advised to seek psychological help?
- Have you received psychological care?
- Have you traveled outside the U.S.?

Where? \_\_\_\_\_

Comment on **ALL** positive answers: \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

**ALLERGIES (medicine, food, other):** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

## Immunization Record (Please attach a copy of immunizations)

**Immunity is required prior to registration.** You must be in compliance with the immunization requirements before you will be officially enrolled at Baker University.

### REQUIRED IMMUNIZATION FOR STUDENTS RESIDING IN RESIDENCE HALLS

#### Meningitis (Menomune or Menactra) \_\_\_\_\_

Waiver of Meningococcal Meningitis Immunization (Does NOT receive Vaccination)  
I have chosen NOT to be immunized. My signature below signifies that I have received and read the material provided to me on meningitis by Baker University.

Signature of Student Required (if waiving vaccine) \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian if student is under 18)

#### MMR (Measles, Mumps, Rubella)

- Dose 1: Immunized after 12 months of age \_\_\_\_\_
- Dose 2: Immunized at 5 years or later \_\_\_\_\_

\*According to Kansas State Dept. of Health & Environment, all students born after 1957 must have two doses of the measles, mumps, and rubella (MMR) vaccine.

#### Tetanus-Diphtheria (Td or Tdap)

- Completed primary series of tetanus-diphtheria immunizations \_\_\_\_\_
- Received tetanus-diphtheria booster within the last 10 years \_\_\_\_\_

#### Polio

- Completed primary series of polio immunization \_\_\_\_\_  
 yes  no

#### RECOMMENDED IMMUNIZATIONS:

##### Tuberculosis (PPD) (Check appropriate answers)

- PPD (Mantoux) test within the past year  
Results:  Negative \_\_\_\_\_  
 Positive: State size of reaction in m.m.
- Positive PPD — Chest x-ray required.  
Results:  Negative \_\_\_\_\_  
 Positive: Send copy of your chest x-ray report & treatment report
- Had BCG vaccine — Chest x-ray required if PPD not done  
Results:  Negative  Positive \_\_\_\_\_

#### Hepatitis B

- #1 \_\_\_\_\_  #2 \_\_\_\_\_  #3 \_\_\_\_\_

#### Hepatitis A

- #1 \_\_\_\_\_  #2 \_\_\_\_\_

#### HPV Vaccine (Gardasil):

- #1 \_\_\_\_\_  #2 \_\_\_\_\_  #3 \_\_\_\_\_

#### Religious/Philosophical Exemption to Immunization Requirement

I \_\_\_\_\_ or \_\_\_\_\_ object to the immunization of (circle) myself/the above named student to measles, rubella, mumps, diphtheria/tetanus, polio. It is understood that exposure to these communicable diseases may cause disabilities and complications. In the event of a measles, rubella, mumps or meningitis outbreak on campus, the above named student will be excluded from campus.

#### The final step...

This form is kept on file in the Student Health Center as a permanent part of your health record. **Please return form, copy of immunizations, and copy of insurance card to: Student Health Center  
P.O. Box 65  
Baldwin City, Kansas 66006**

#### PERMISSION FOR MEDICAL TREATMENT

Permission is hereby given for treatment in the Baker University Student Health Center and for transportation by ambulance and hospitalization, if needed.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian if student is under 18)