

HEALTH HISTORY FORM

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: _____

city state zip

Date of Birth _____

Home Phone # (____) _____

Cell Phone # of student (____) _____

SSN# _____

Date Entering Baker _____

Gender: Female Male

Marital Status:

Single Married Widowed Divorced

Father's/Spouse's Name _____

Address _____
 (if different from above)

Father's Cell _____

Father's/Spouse's Employer _____

Work Phone _____

Mother's/Spouse's Name _____

Address _____
 (if different from above)

Mother's Cell _____

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: _____

Student athletes are required to document an annual physical exam for clearance in their particular sport. (see Baker Athletics Sports Medicine site for forms) www.bakeru.edu/athletics2/sports-medicine

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.

For the (health) record



BAKER
 UNIVERSITY

Have you had...?

Yes	No	ACUTE INFECTIOUS DISEASES
<input type="radio"/>	<input type="radio"/>	Chicken Pox
<input type="radio"/>	<input type="radio"/>	Hepatitis
<input type="radio"/>	<input type="radio"/>	Infectious Mononucleosis (mono)
<input type="radio"/>	<input type="radio"/>	Pneumonia
<input type="radio"/>	<input type="radio"/>	Tonsillitis
<input type="radio"/>	<input type="radio"/>	Typhoid
<input type="radio"/>	<input type="radio"/>	Sexually Transmitted Diseases
<input type="radio"/>	<input type="radio"/>	Measles
<input type="radio"/>	<input type="radio"/>	Mumps
<input type="radio"/>	<input type="radio"/>	Other _____
Yes	No	OTHER DISEASES
<input type="radio"/>	<input type="radio"/>	Alcoholism/Drug Addiction
<input type="radio"/>	<input type="radio"/>	Anemia
<input type="radio"/>	<input type="radio"/>	Anorexia/Bulimia
<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	Cancer
<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis
<input type="radio"/>	<input type="radio"/>	Chronic Skin Disease (eczema, psoriasis)
<input type="radio"/>	<input type="radio"/>	Convulsions, Seizures (epilepsy)
<input type="radio"/>	<input type="radio"/>	Dental Problems
<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Digestive Tract Disease (ulcer, colitis)
<input type="radio"/>	<input type="radio"/>	Gallbladder/Liver Disease
<input type="radio"/>	<input type="radio"/>	Glaucoma
<input type="radio"/>	<input type="radio"/>	Hay Fever
<input type="radio"/>	<input type="radio"/>	Heart Disease (rheumatic fever, murmur)
<input type="radio"/>	<input type="radio"/>	High Blood Pressure
<input type="radio"/>	<input type="radio"/>	Kidney or Bladder Disease
<input type="radio"/>	<input type="radio"/>	Malaria
<input type="radio"/>	<input type="radio"/>	Orthopedic Problems (knee, back)
<input type="radio"/>	<input type="radio"/>	Prolonged Depression or Anxiety
<input type="radio"/>	<input type="radio"/>	Speech, Hearing, Vision Problems
<input type="radio"/>	<input type="radio"/>	Severe Headache (migraine)
<input type="radio"/>	<input type="radio"/>	Thrombophlebitis
<input type="radio"/>	<input type="radio"/>	Thyroid or Endocrine Disturbance
<input type="radio"/>	<input type="radio"/>	Tuberculosis
<input type="radio"/>	<input type="radio"/>	Other: _____
Yes	No	OTHER HEALTH CARE HISTORY
<input type="radio"/>	<input type="radio"/>	Have you ever been hospitalized?
<input type="radio"/>	<input type="radio"/>	Have you had any surgical operations?
<input type="radio"/>	<input type="radio"/>	Are you under medical treatment?
<input type="radio"/>	<input type="radio"/>	Do you take any prescribed medicine or injection?
<input type="radio"/>	<input type="radio"/>	Do you have physical disabilities?
<input type="radio"/>	<input type="radio"/>	Do you need any special accommodations?
<input type="radio"/>	<input type="radio"/>	Have you been advised to seek psychological help?
<input type="radio"/>	<input type="radio"/>	Have you received psychological care?
<input type="radio"/>	<input type="radio"/>	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 to avoid a **HOLD** on your records at the Office of the University Registrar.

REQUIRED IMMUNIZATIONS:

Meningitis (Menveo or Menactra) - Mandatory

MM DD YY

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)
(Parent/Guardian if student is under 18)

Date

MMR (Measles, Mumps, Rubella)

Dose 1: Immunized after 12 months of age

MM DD YY

Dose 2: Immunized at 5 years or later

MM DD YY

*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) - Within last five years

Completed primary series of tetanus-diphtheria immunizations

MM DD YY

Received tetanus-diphtheria booster within the last 5 years

MM DD YY

Polio

Completed primary series of polio immunization

yes no

MM DD YY

RECOMMENDED IMMUNIZATIONS:

Tuberculosis (PPD) (Check appropriate answers)

PPD (Mantoux) test within the past year

MM DD YY

Results: Negative

Positive: State size of reaction in m.m.

Positive PPD – Chest x-ray required.

MM DD YY

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

MM DD YY

Hepatitis B

#1

MM DD YY

#2

MM DD YY

#3

MM DD YY

Hepatitis A

#1

MM DD YY

#2

MM DD YY

HPV Vaccine (Gardasil):

#1

MM DD YY

#2

MM DD YY

#3

MM DD YY

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)