Health History Form

BAKER UNIVERSITY
1858

Please complete and **return by August 1st to:**

Student Health Center
P.O. Box 65
Baldwin City, Kansas 66006
785.594.8409   Fax: 785.594.8314

PLEASE INCLUDE: •COPY OF IMMUNIZATION RECORD

This form is kept on file in the Student Health Center as a permanent part of your health record. This form can be completed online at www.bakerU.edu/healthform.

Student Information:

Name (please print): ______________________________

Date of Birth: ______________ Student Phone #: ______________

SSN #: ______________ Date Entering Baker: ○ Fall ○ Spring Year________

Race: ○ White ○ Black or African American ○ Native Hawaiian & other Pacific Islander
○ Asian ○ Hispanic or Latino ○ American Indian & Alaska Native ○ Other ______________

Gender: ○ Male ○ Female ○ Other______________

Father's Name: ______________________________ Phone: ______________

Mother's Name: ______________________________ Phone: ______________

Person to Call in an Emergency: ______________________________

Phone: ______________ Relationship: ______________

Medical History:

Family History: (place relationship in blank)

○ Alcohol/Drug Abuse ______________
○ Heart Disease ______________
○ Seizures ______________
○ Death before 50 ______________
○ Asthma ______________
○ High Blood Pressure______________
○ Tuberculosis ______________
○ Depression/Anxiety______________
○ Cancer/Type ______________
○ Stroke ______________
○ Diabetes ______________
○ Other______________

Disease/Illness History: Check all that you have now or have ever had:

❍ Alcoholism/Drug Addiction
❍ Anemia
❍ Anorexia/Bulimia
❍ Asthma
❍ Cancer
❍ Chicken Pox
❍ Chronic Bronchitis
❍ Chronic Skin Disease (eczema, psoriasis)
❍ Convulsions, Seizures (epilepsy)
❍ Dental Problems
❍ Diabetes
❍ Digestive Tract Disease (ulcer, colitis)
❍ Gallbladder/Liver Disease
❍ Glaucoma
❍ HIV/AIDS
❍ Heart Disease (rheumatic fever, murmur)
❍ Hepatitis
❍ High Blood Pressure
❍ Infectious Mononucleosis (mono)
❍ Kidney or Bladder Disease
❍ Malaria
❍ Measles
❍ Mumps
❍ Orthopedic Problems (knee, back)
❍ Pneumonia
❍ Prolonged Depression or Anxiety
❍ Severe Headache (migraine)
❍ Sexually Transmitted Diseases
❍ Speech, Hearing, Vision Problems
❍ Thyroid or Endocrine Disturbance
❍ Tonsillitis
❍ Tuberculosis
❍ Typhoid

Health Information:

Current/Chronic Health Concerns:______________________________

____

Surgical History:______________________________

____

Health Information: (cont.)

Current Medications:____

____

Allergies (medicine, food, other):____

____

Tuberculosis (TB) Screening

The state of Kansas requires each incoming university student (freshman and transfer) to complete the TB (tuberculosis) screening. Please complete the four questions below.

1. Have you ever had a **POSITIVE** TB (tuberculosis) skin test? ○ Yes ○ No
2. Have you lived with, or had close contact with anyone who was sick with tuberculosis? ○ Yes ○ No
3. Were you born in a country other than the United Sates? ○ Yes ○ No
   If yes, country____
4. Have you traveled or lived 3 consecutive months in any country other than the United States? ○ Yes ○ No
   If yes, country____

To review the at-risk countries go to www.stoptb.org/countries/tbdata.asp

Immunization Record: (Please attach a copy of immunizations).

Baker University requires students, regardless of age, to submit a copy of their updated immunization records. This documentation can be a personal immunization record signed by a health care provider, a physician or clinic report stating all immunization records or a copy of school immunization records. It must include the 4 **REQUIRED** immunizations.

1. MMR (Measles, Mumps, Rubella) immunization. Two doses required at least 28 days apart for students born after 1956.
2. Tdap (Tetanus, Diphtheria, and Pertussis) immunization booster within the last 10 years.
3. Meningitis (MCV4) immunization. Two doses of MCV4 are recommended. If the first dose is given before the 16th birthday, then a booster is required.
4. Polio series completed. Primary series, doses at least 28 days apart. Three primary series are acceptable.

Waiver of Meningococcal Meningitis Immunization: (Does NOT receive vaccination)

I have chosen NOT to be immunized for Meningitis. My signature below signifies that I understand I will be removed from housing and not allowed to attend classes, in the event of a Meningitis outbreak on campus.

Signature of Student Required (if waiving vaccine) ____ Date________________________

(Parent/Guardian if student is under 18)

Religious/Philosophical Exemption to Immunization Requirement:

I object to the immunization to measles, mumps, rubella, diphtheria/tetanus, polio. It is understood that exposure to these communicable diseases may cause disabilities and complications. My signature below signifies that I understand I will be removed from housing and not allowed to attend classes, in the event of measles, mumps, rubella or meningitis outbreak on campus.

Signature of Student Required (if waiving vaccinations) ______________________________________ Date______________________

(Parent/Guardian if student is under 18)

PERMISSION FOR MEDICAL TREATMENT

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

➡ **Signature of Student**____**D**ate________________________

(Parent/Guardian if student is under 18)

Office Use Only:

Meningitis

❍ #1 _____________, _____ ❍ #2 _____________, _____
MM DD YY AGE MM DD YY AGE

MMR (Measles, Mumps, Rubella)

❍ #1 ____________ ❍ #2 ____________
MM DD YY MM DD YY

Polio

❍ Series Completed _____________
MM DD YY

Tdap (Tetanus)

❍ Series Completed _____________ ❍ Within 10 yrs _____________
MM DD YY MM DD YY

Hepatitis B

❍ #1 ____________ ❍ #2 ____________ ❍ #3 ____________
MM DD YY MM DD YY MM DD YY

Hepatitis A

❍ #1 ____________ ❍ #2 ____________
MM DD YY MM DD YY

HPV Vaccine (Gardasil):

❍ #1 ____________ ❍ #2 ____________ ❍ #3 ____________
MM DD YY MM DD YY MM DD YY

Varicella: Date of Disease

❍ #1 ____________ ❍ #2 ____________ ❍ ____________
MM DD YY MM DD YY MM DD YY