



# MORNINGSIDE COLLEGE

## STUDENT HEALTH FORM

Drug Allergies: \_\_\_\_\_

**HEALTH FORM including IMMUNIZATIONS REQUIRED FOR ALL STUDENTS (enrolled 9 or more hours) ENTERING AS A FRESHMAN, TRANSFER OR READMIT. Please fill out the front page and the top of the back page before going to your physician. This form must be received and immunization status approved before you are permitted to attend class. Please print all information.**

Full name \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Initial Circle one M D Y

Home Address \_\_\_\_\_  
Street Address City State Zip

Student's E-mail Address \_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_ Student's Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_ Business Phone Number (\_\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_  
Street Address City State Zip

Emergency contact \_\_\_\_\_  
Full Name Relationship Phone #1 Phone #2

Emergency contact \_\_\_\_\_  
Street Address City State Zip

Family Physician \_\_\_\_\_  
Name Street Address City, State, Zip Phone Number

Date of entry to Morningside \_\_\_\_/\_\_\_\_/\_\_\_\_ Entering as: First-year \_\_\_\_ Transfer \_\_\_\_ Returning \_\_\_\_ Residence: On Campus \_\_\_\_ Commuter \_\_\_\_  
Month/Year

**Family History**

Age	State of Health	Occupation	Age, Cause of Death	What relative currently has or has had:
Father				Tuberculosis _____
Mother				Diabetes _____
Brother				Kidney Disease _____
Brother				Heart Disease _____
				Asthma, Hay Fever _____
Sister				Cancer _____
Sister				High Blood Pressure _____
				Epilepsy, Convulsions _____

**Personal History (Please answer all questions)**

Have you had or are you concerned about?	Yes	No		Yes	No		Yes	No		Yes	No
Alcohol use			Depression			Mumps			Tuberculosis		
Asthma, Hay Fever			Indigestion			Pneumonia			Urinary Tract Problems		
Back Problem			Gallbladder Trouble			Polio			Sexually Trsm Disease		
Cancer, cyst			Gum/Tooth Trouble			Recent Wt. Gain/Loss			Weakness, Paralysis		
Chemical Dependency			Head Injury			Recurrent Colds			Worry, Nervousness		
Chest pain/pressure			Heart Murmur			Recurrent Diarrhea			Female Students:		
Chronic Cough			Heart Palpitation			Recurrent Headaches			Irregular Periods		
Diabetes			High/Low Blood Pressure			Rheumatic Fever			Severe Cramps		
Dizziness/Fainting			Jaundice			Scarlet Fever			Excessive Flow		
Ear/Nose/Throat Trouble			Joint Injury/Disease			Shortness of Breath			Pregnancy		
Eating Disorder			Malaria			Sinusitis			Other Conditions		
Epilepsy/Seizure Disorder			Measles			Stomach/Intestinal Trble					
Eye Trouble			Measles (German)			Suicidal Thoughts					
Anxiety/Panic Attacks			Mononucleosis			Trouble Sleeping					

Is there anything not covered above that you feel Health Services should be aware of? Please describe: \_\_\_\_\_

Medications currently taking (and reason): \_\_\_\_\_

	Yes	No	Please explain any "yes" responses
Have you had any illness or injury or surgery which required hospitalization?	_____	_____	_____
Have you consulted or been treated by clinic, physician, or other practitioners within the past five years?	_____	_____	_____
If so, have any of your activities been restricted in the past five years?	_____	_____	_____
Have you been rejected or discharged from military service because of physical, emotional or other reasons?	_____	_____	_____
Have you had any special difficulties with school or teachers?	_____	_____	_____
Have you ever experienced any personal or emotional difficulties which require professional attention?	_____	_____	_____

# IMMUNIZATION RECORD

Full name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

EMERGENCY TREATMENT CONSENT: In case of an accident or emergency in which I may be unable to direct my own medical care, I authorize Morningside College to seek appropriate medical/surgical care for me until those identified as emergency contact persons can be notified. I hereby state that the above information is true and give permission for Health Services to release information to health care providers and facilities who are included in my treatment.

If under 18, must be signed by **both** student and parent and/or guardian.

Student Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Check here if you would like to receive a copy of our "Notice of Privacy Practices".

Must be completed by a **Health Care Provider** prior to new-student registration and is **REQUIRED** for all students born after 1956.

## REQUIRED IMMUNIZATIONS

### MENINGOCOCCAL IMMUNIZATION – VACCINE OR SIGNATURE REQUIRED

- (1) Meningococcal - The American College Health Association **recommends** that students consider a one-time dose meningitis vaccine to reduce the risk for potentially fatal bacterial meningitis. (For questions, read information at Centers for Disease Control website: [www.cdc.gov/nip/publications/VIS/vis-mening.pdf](http://www.cdc.gov/nip/publications/VIS/vis-mening.pdf) AND consult your health care provider.)

I have received information about meningococcal disease and choose not to receive the vaccine at this time:

Signature required if **not** receiving vaccine. \_\_\_\_\_ Date \_\_\_\_\_

\* I HAVE RECEIVED VACCINE: (Preferred) Menactra (MCV4) Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Menomune ( MPSV4) Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_

- (2) **M.M.R.** (Measles, Mumps, Rubella) - **2 Doses Required** Dose #1 (15 mo. or after) \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 (5 yrs. or after) \_\_\_\_/\_\_\_\_/\_\_\_\_  
If given as separate doses please identify: **Measles:** #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ **Mumps:** #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ **Rubella:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\* NOTE: If born prior to 1957 you are considered immune and require no further vaccination.

- (3) **Tetanus/Diphtheria/Pertussis (Required)** Primary Series Completed \_\_\_\_/\_\_\_\_/\_\_\_\_ Booster (within last 10 years) \_\_\_\_/\_\_\_\_/\_\_\_\_ Tdap Boost.? \_\_\_\_\_  
Date: \_\_\_\_\_

- (4) **Polio (Required)** Primary Series Completed \_\_\_\_/\_\_\_\_/\_\_\_\_

### (5) Tuberculosis Screening

- Does the student have signs or symptoms of **active tuberculosis** disease? Yes \_\_\_ No \_\_\_ If No, proceed to #2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
- Is the student a member of a high-risk group or is the student entering the health profession? Yes \_\_\_ No \_\_\_ If No STOP. If Yes, enter tuberculin skin test (Mantoux only) below. A *history of BCG vaccination should not preclude testing of a member of a high-risk group.*
- Tuberculin Skin Test Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_ Interpretation(based on mm of induration as well as risk factors):  
Induration \_\_\_\_\_ mm Positive \_\_\_\_\_ Negative \_\_\_\_\_
- Chest x-ray (if above is positive) Results: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

## RECOMMENDED IMMUNIZATIONS

- (6) **Hepatitis B** Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_

- (7) **Varicella** (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)

History of disease: Yes \_\_\_ No \_\_\_ Varicella antibody \_\_\_\_/\_\_\_\_/\_\_\_\_ Reactive \_\_\_ Non-reactive \_\_\_ Immunization: Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

(Dose #2 given at least one month after first dose, if age 13 years or older.)

- (8) **Quadrivalent Human Papilloma Vaccine (HPV)** Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_

- (9) **Hepatitis A** Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the patient now under treatment or medication for any medical or emotional condition? \_\_\_ Yes \_\_\_ No

Recommendations regarding the care of this student: \_\_\_\_\_

Physician's/ Health Care Provider's Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Provider's Name: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone Number

Provider's Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

**Mail Completed Form To:**  
Morningside College Student Health  
1501 Morningside Ave  
Sioux City IA 51106

The Morningside College experience cultivates a passion for life-long learning and a dedication to ethical leadership and civic responsibility.