Updated 6/17/2025

MORNINGSIDE UNIVERSITY

STUDENT 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 University to seek appropriate care for me until those identified as emergency contact persons can be notified. I hereby state that the above information is true and I give permission for Morningside University 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

REQUIRED IMMUNIZATIONS

(1) MENINGOCOCCAL IMMUNIZATION - VACCINE OR SIGNATURE REQUIRED
Please read the information at www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html AND consult with your health care provider.
I have received the 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) MCV4 Vaccine ___/___/___ **2 DOSES MENINGITIS B** ___/___/___ ___/___/___

Date of Booster: ___/___/___ Students should have documentation of having received this vaccine after their 16th birthday.

(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** ___/___/___

(3) Tetanus/Diphtheria/Pertussis: Primary Series Completed ___/___/___ Current TDAP Booster ___/___/___

(4) Polio: Primary Series Completed ___/___/___

(5) Tuberculosis Screening: (Health Care Provider To Determine) THIS IS REQUIRED FOR ALL INTERNATIONAL STUDENTS

1. Does the student have signs or symptoms of active tuberculosis disease? Yes ___ No ___ If no, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray adn sputume valuation as indicated.
2. 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 memeber of a high-risk group.
3. Tuberculin Skin Test: Date given: ___/___/___ Date read: ___/___/___ Interpretation (based on mm duration as well as risk factors)
4. Chest x-ray (if above is positive): Results: Normal ___ Abnormal __ Date of chest x-ray ___/___/___

If you have a medical or religious reason for not receiving immunizations, please provide a copy of the medical or religious certificate with your health forms. If you have any questions related to this, please contact Student Health with any questions.

RECOMMENDED IMMUNIZATIONS

(6) Hepatitus B: Dose #1 ___/___/___ **Dose #2** ___/___/___ **Dose #3** ___/___/___

(7) Varicella: (A history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart.)
History of the disease: Yes __ No __ Varicella antibody ___/___/___ Reactive __ Non-reactive __
Immunization: **#1** ___/___/___ **Dose #2** ___/___/___

(8) Quadrivalent Human Papilloma Vaccine (HPV) **#1** ___/___/___ **Dose #2** ___/___/___ **Dose #3** ___/___/___

(9) Hapatitis A **Dose #1** ___/___/___ **Dose #2** ___/___/___

Is the student now under treatment or medical or emotional condition: Yes__ No__
Recommendations regarding the care for this student: _____

_____

_____

Mail completed original form to: Morningside University Student Health, 1501 Morningside Avenue, Sioux City IA, 51106

MORNINGSIDE UNIVERSITY
STUDENT HEALTH HISTORY

Today's Date _____

Name _____ Sex _____ Date of Birth _____

Email _____

Address _____ Student Phone _____

Individual Providing Health History-- and relationship to student (if not student): _____

Emergency Contact #1 _____ Phone _____

Emergency Contact #2 _____ Phone _____

Current Health Care Provider Name _____ Phone _____

Are you a veteran? Yes__ No__

PERSONAL HEALTH HISTORY

Please mark below any conditions that you have experienced or are currently diagnosed with

Alcohol Use		Anemia		Anxiety		Arthritis	
Asthma		ADD/ADHD		Bladder/Bowel Issues		Cancer	
Depression		Diabetes		Eating Disorder		Fractures	
Head Injury		Hearing Loss		Heart Murmur		Heart Problems	
High Blood Pressure		Kidney Disease		Orthopedic Issues		Seizures	
Sickle Cell Trait		Thyroid Disease		Tobacco Use		Vision Issues	

Please explain any conditions or current treatments for conditions:

_____

_____

Do you have any life-threatening allergies to food or medicine? Yes__ No__
If yes, please list: _____

Have you had any hospitalizations, significant injuries, or surgery? Yes__ No__
If yes, please explain: _____

Do you take medicine or supplements daily? Yes__ No__
If yes, please list: _____

FAMILY HISTORY

	Age	Serious Health Conditions	Occupation	Age & Cause of Death
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				

Please list any additional concerns or information not covered. (Use separate page as needed). _____

_____

_____