Carroll University Student Health Center

100 N. East Ave., Waukesha, WI 53186 ph: 262-524-7233 fax: 262-650-4897

HEALTH HISTORY: Please print. Please complete both sides.

Name: _____ Male _____ Female _____
(Last) (First) (Middle)

Address_____
(street address) (City) (State) (Zip)

Date of Birth _____ Married_____ Single_____ Birth Country_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone: Home _____
Work _____
Cell _____

Date of Enrollment:_____ **As:** Freshman Sophomore Junior Senior Graduate student

MEDICAL HISTORY—Have you ever had any of the following: (check if applicable)

___ Alcohol Abuse
___ Anemia
___ Arthritis
___ Asthma
___ Back Problems
___ Cancer
___ Chicken Pox
___ Colitis
___ Convulsions/Seizures
___ Chronic Cough
___ Depression
___ Diabetes
___ Disability
___ Drug Abuse
___ Eating Disorder
___ Hayfever
___ Hepatitis
___ Headache / Chronic
___ Heart Disease
___ Head Injury
___ Heart Murmur
___ Hemophilia
___ Hernia
___ High Blood Pressure
___ High Cholesterol
___ Intestinal / Stomach Disorders
___ Kidney Disease
___ Loss of Consciousness / Fainting
___ Malaria
___ Measles
___ Menstrual Problems
___ Migraine Headache
___ Mono
___ Mumps
___ Orthopedic Problems
___ Pneumonia
___ Polio
___ Psychological Counseling
___ Rheumatic Fever
___ Sickle Cell Disease
___ Sinus Infections
___ Sleep Disorder
___ Spleen Removed
___ Stroke
___ **TB**
___ Positive **TB** Skin Test
___ Thyroid Disease
___ Urinary / Bladder Infections

Brief explanation of any **positive** responses:

_____
_____

History of Surgery: Yes No

_____
If Yes, List

Ongoing Medical / Psychological Problems: Yes No **Are you seeing a health care provider regularly**? Yes No

_____
_____
If Yes, List

Medications being taken:

_____ _____
_____ _____
_____ _____

Medication Allergies: Yes No

_____
(List Medication/Reaction)
_____

Environmental Allergies:

_____

Tobacco Use: Yes No Type _____ Frequency _____

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Please complete other side

Name_____ Birth Date_____

Please print

IMMUNIZATION RECORD

Vaccine	Date	Date			
Measles, Mumps, Rubella (MMR) (Month/Day/Year)	#1	#2	• Two doses of MMR vaccine are required. • The first MMR must have been given no earlier than 4 days before the first birthday. The 2nd dose of measles, mumps and rubella vaccine or of measles vaccine must have been administered at least 28 calendar days after the 1st dose. • In lieu of immunization, written evidence of laboratory tests showing immunity to measles, mumps, rubella is acceptable. Attach written proof. • Measles, mumps and rubella (MMR) is not required for college students born before January 1957.		
Hepatitis A (Month/Day/Year)	#1	#2	Recommended for routine use in all adolescents through the age of 18 and in particular for high-risk groups (i.e., persons traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and noninjectable drugs, persons who have clotting-factor disorders, persons working with nonhuman primates, and persons with chronic liver disease).		
Hepatitis B (Month/Day/Year)	#1	#2	#3	Recommended for all college students.	
Human Papillomavirus (HPV) (Month/Day/Year)	#1	#2	#3	Recommended for all females 11-26 years old and for all males 11-21 years old, males 11-26 years old who have sex with men, and 11-26 year old males with compromised immune systems. Other males 22-26 years old may be vaccinated.	
Meningococcal / Menactra (Month/Day/Year)	#1	#2	One or two doses recommended for all students, especially for college students living in residence halls. If first dose given before age 16, a booster is recommended. If initial dose given age ≥16years, no booster dose required.		
DTP (diphtheria, tetanus, pertussis) (Month/Day/Year)	#1	#2	#3	#4	#5
Polio (Month/Day/Year)	#1	#2	#3	#4	
Varicella / Chicken pox (Month/Day/Year)	#1	#2	**OR**- History of Disease (Month/Year)	Recommended for all college students without evidence of immunity (e.g. history of disease, two doses of vaccine, or a positive antibody).	
Td Booster (tetanus diphtheria) (Month/Day/Year) **(within last 10 yrs.)**	#1	**Or Tdap Booster (**Td Pertussis**)** (Month/Day/Year) **One dose required**	#1	**An Immunization Waiver can be requested by calling 262-524-7233. Please note that students who are incompletely vaccinated may be excluded from class if an outbreak of a vaccine preventable disease occurs on campus.**	
TB Vaccine (BCG) Bacille Calmette-Guérin (BCG)	#1	#2	The BCG vaccine is not required or recommended in the U.S. However, the BCG vaccine is often given to infants and small children in other countries where TB is common. If you have had the BCG vaccine, please document the dates it was given to help determine which type of TB test is best for you.		

If form completed by physician or other health care provider:

To the best of my knowledge, the person above has received the above immunizations.

Signed_____ Title_____ Date_____

TUBERCULOSIS SCREENING IS REQUIRED FOR NON-U.S. RESIDENTS AND STUDENTS PARTICIPATING IN STUDY ABROAD PROGRAMS IN HIGH RISK AREAS

Non U.S. residents must be screened for tuberculosis (TB) **after arriving on campus in the U.S.** prior to the 25th day of classes. In addition, students who participate in a Carroll University study abroad program in any high incidence area need to be tested for TB 8 to 10 weeks after returning to the U.S. Visit the Student Health Center web page to view the full policy found under handouts. Appendix A lists high incidence countries:https://my.carrollu.edu/ICS/Departments/Health_Services/ Failure to comply with this policy by the 25th day of classes, or by 10 weeks after return from studying abroad to a high incidence area, may result in a hold being placed on the student's registration. In addition, the Director of International Education and the Dean of Students will be notified if a student fails to comply with the policy.

AUTHORIZATION FOR MEDICAL TREATMENT

For All Students: By signature, I verify that the information on this form is accurate and true. By signature, I give permission to the staff at Carroll University Health Center to administer any medical care that might be deemed necessary for my health and well being. I grant permission for emergency treatment and/or hospitalization at an accredited hospital when necessary.

I have read detailed information about the risks associated with Meningococcal disease and Hepatitis B and the availability and effectiveness of vaccination against these diseases. If not, see http://www.cdc.gov/vaccines/pubs/vis/default.htm

_____ Date_____

Signature of student ≥ 18 yrs of age

_____ Date_____

Signature of parent / guardian if student is < 18 yrs of age