

Health Form

Term of Entry: Fall ____ Spring ____ 20____ Resident ____ Commuter ____

All students are required to complete the health form. All information is confidential and for Health Service use only.

PERSONAL HISTORY *Please print clearly.*

Name _____ Soc. Sec. # _____
(Last) (First) (Initial)

Home address _____ City _____ State _____ Zip Code _____

Phone (Home) () _____ (Work) () _____ Date of birth _____

Name of parents, guardian or spouse _____

Whom should we call in an emergency? #1 Name _____ Phone (H) () _____ (W) () _____

#2 Name _____ Phone (H) () _____ (W) () _____

MEDICAL HISTORY

Are you allergic to any medications? _____ Please list: _____

Are you taking any medications (including oral contraceptives) on a regular basis? _____ Please list all prescriptions and the reason for taking these.

Do you currently have an illness or disability that requires medical treatment? Please list: i.e., diabetes, seizure disorder, heart condition, ADD or asthma (if using peak flow meter please bring with you to school) _____

Do you have any special needs that Student Services can assist you with or that may require follow up? If necessary, attach medical verification. _____

PAST HISTORY

Have you had any major illnesses (medical, surgical, or psychiatric) in the past? Please list any hospitalization or operations performed:

FAMILY HISTORY

| Name | Age | Occupation | Current health status, medical history or cause of death | Age of death |
|------------------|-----|------------|--|--------------|
| Father | | | | |
| Mother | | | | |
| Brothers/Sisters | | | | |
| | | | | |
| | | | | |

IMMUNIZATION HISTORY Date of Birth ____/____/____ Place of birth _____

PLEASE READ CAREFULLY Illinois law requires incoming students born **AFTER 1956** to document proof of immunity to measles, rubella, mumps and tetanus/diphtheria. Please provide month, day and year for each dose administered. **This must be verified by your family physician or you can request a copy of your high school immunization record and include that with this form.**

DPT#1 ____/____/____

MMR#1 ____/____/____

DPT#2 ____/____/____

MMR#2 ____/____/____

DPT#3 ____/____/____

Lab verification of immunity if titers done

Td within the last 10 years ____/____/____

If MMR not used: Measles (Rubeola) #1 ____/____/____

German Measles (Rubella) ____/____/____

Measles (Rubeola) #2 ____/____/____

Mumps ____/____/____

Hepatitis (**recommended**) #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

Menomune-A/C/Y/W-135 (vaccine for Meningitis) (**strongly advised**) ____/____/____

All international students should receive a PPD or a chest X-ray within past 6 months

PPD ____/____/____ Results _____ Chest X-ray ____/____/____ Results _____

Verification by family doctor or registered nurse from office: (**may also include copy of high school health record**)

SIGNATURE DATE

OFFICE STAMP HERE:

SIGNATURE DATE

CONSENT FOR EMERGENCY TREATMENT

I consent to emergency medical treatment while I am enrolled as a student at Springfield College in Illinois. I agree to be responsible for any financial cost associated with any of the above mentioned care. The College is not responsible for any of these payments.

Date ____/____/____ Signature of student _____

Date ____/____/____ Signature of parent or guardian _____

FOR OFFICE USE ONLY

Incomplete information: _____

Student notified: _____ Complete: _____ Date: _____