McKendree University

Confidential Medical History and Immunization Record

Students are *required* to have the following information completed before they can reside in student housing or register for classes. Failure to comply with the Illinois State Mandate will result in a $50.00 fee and a HOLD being placed on registration by the Office of Health Services.

To be completed by the student:

Name:_____ **Date of Birth** _____
(last) (first) (middle)

Home Address: _____
(number and street) (city) (state) (ZIP)

Mailing Address: _____
(if different from above)

Part I. Confidential Medical History

Have you had or are you subject to any of the following? Please give dates.

____Appendicitis	**____Pelvic Disorders**	**____Kidney Troubles**	**____Asthma**
____Chickenpox	**____Diabetes**	**____Hernia**	**____Poliomyelitis**
____Tonsillitis	**____Hay Fever**	**____Scarlet Fever**	**____Pleurisy**
____Typhoid Fever	**____Pneumonia**	**____Skin Disease**	**____Malaria**
____Measles	**____Epilepsy**	**____Rheumatic Fever**	**____Abdominal Pain**
____Mental Illness	**____Heart Trouble**	**____Tuberculosis**	**____Emotional Problem**
____Shortness of Breath	**____Moody**	**____Headaches**	**____Defective Vision**
____High Blood Pressure	**____Cough**	**____Whooping Cough**	**____Mononucleosis**
____Joint Pains	**____German Measles**	**____Sinus Infection**	**____Joint Pains**
____Diphtheria	**____Mumps**	**____Defective Hearing**	**____Jaundice**
____Family History of High Blood Pressure			

Do you know of any physical disability which may make it unwise for you to engage in Physical Education activities? Explain:
_____
_____

Do you have any food and/or medication allergies? _____
_____

Are you on any maintenance medication and for what condition? _____
_____

Please add any further notes about your health which you think might be of value to the Office of Health Services:
_____
_____

Injuries: _____ **Date:** _____
_____ **Date:** _____
Operations: _____ **Date:** _____
_____ **Date:** _____

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Insurance

(Note: It is *mandatory* for all international students to obtain health insurance prior to final course registration):

Policy Number of Insurance Company: _____ Name of company: _____

City: _____ State: _____ Country: _____ Postal Code: _____

Social Security Number of Student (If applicable): _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Telephone: Business: _____ Residence: _____

Privacy Rights Waiver

Information in this medical report may be used to plan health care, adjudicate claims, provide classification for physical activities, and control communicable disease. In order to provide health care, the above named persons (or a substitute) may be given information judged necessary by an authority representing McKendree University.

Signature of Student: _____Date:_____

(physician's signature)

Part II. Immunization Record

This form must be completed and returned *prior* to students moving-in to campus housing or registering for classes. A copy of your immunizations (available at your high school, doctor's office, or previously attended university) may be faxed to Health Services at (618) 537-6955 or attached to this form in place of completing this section. All dates must include month/day/year.

To be completed by the physician:

Required Immunizations

If immunization records are not available then students are *required* to receive the titer blood test which shows proof of immunity to MMR and show proof of the DT booster received within the last 10 years.

1. **Measles, Mumps. and Rubella**

   It is *mandatory* for incoming new students born on or after January 1, 1957, to document immunity to measles, mumps, and rubella prior to enrollment. Two doses of live measles vaccine on or after first birthday, at least one (1) month apart, or evidence of measles immunity (i.e. prior physician diagnosed measles disease or laboratory evidence of immunity). If second dose is necessary it must be given as a M.M.R. (Measles, Mumps, Rubella.)

   a. **Measles (Rubeola, Old Fashioned, Ten Day):**

      Disease diagnosed by:_____Date:_____

      (physician's signature)

      Measles vaccine date: _____

      (month / day / year)

      Laboratory evidence of immunity date: _____ Results: _____

      (month / day / year) (Attach copy of laboratory report)

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b. Mumps:

Disease diagnosed by:_____ **Date:**_____
(physician's signature)

Mumps vaccine date: _____
(month / day / year)

c. Rubella (Three Day, German Measles)*:

Rubella vaccine date: _____
(month / day / year)

Laboratory evidence of immunity date: _____ **Results:**_____
(month / day / year) (Attach copy of laboratory report)

History of the disease is not acceptable as proof of immunity for rubella.

2. Tetanus/Diphtheria

It is *mandatory* for incoming new students born on or after January 1, 1957, to document immunity to tetanus and diphtheria prior to enrollment.

Dates of original series of DTP, DT and/or Td: 1. _____ **2.** _____ **3.** _____
(month / day / year) (month / day / year) (month / day / year)

Most recent booster: _____ **(Td booster must have been within the past ten [10] years).**
(month / day / year)

3. Laboratory Work (Required for International students *only*):

Blood Analysis: **Date:** _____ **Hemoglobin:** _____ **Hematocrit:** _____

Urinalysis: **Date:** _____ **Specific Gravity:** _____ **Albumin:** _____

Sugar: _____ **Blood:** _____ **Micro:** _____

Tuberculin Test: **Date:** _____ **Results:** _____

If positive, chest X-ray required: **Date:** _____ **Results:** _____

Signature of Physician: _____ **Date:** _____

Name of Physician (print or type): _____

Mailing Address: _____
(number and street) (city) (state) (ZIP)

Office of Health Services
513 Stanton Street
Lebanon, IL 62254
Phone: (618) 537-6503
Fax: (618) 537-6955

Complete: ☐	**Incomplete:** ☐
Reviewer:	**Date:**

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Recommended Immunizations

The following are optional immunizations, but are strongly recommended for all students.

1. Flu Vaccine

Dose ____ / ____ / ____

2. Hepatitis B

Dose 1 ____ / ____ / ____

Dose 2 ____ / ____ / ____

Dose 3 ____ / ____ / ___

3. Meningitis (affects the brain and spinal cord and rapidly progresses to death if not diagnosed and treated)

The Centers for Disease Control (CDC) recommends vaccination of unvaccinated college students, particularly those living in residence halls who are at an increased risk for meningitis. Meningococcal vaccine is available year round for enrolled students. For more information go to http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf

☐ **Menactra** ☐ **Menveo** ☐ **Meningococcal (unspecified)**

4. Quanti-FERON TB-Gold (within past 12 months):

Lab test (attach lab report) **Date: _____**

Has patient had a history of previous positive skin test? ☐ **Yes** ☐ **No**

Has patient received BCG? ☐ **Yes** ☐ **No**

Has patient received INH? ☐ **Yes** ☐ **No** **If "yes" attach a supporting document.**

Tuberculosis Skin Test **Date: _____ Results of skin test: _____mm**

5. Tdap Vaccine (Tetanus/Diphtheria/Acellular Pertussis)

Dose ____ / ____ / ____

6. 2nd Mumps Vaccine

Dose ____ / ____ / ____

7. Varicella

Date of Disease ____ / ____ / ____

OR, Blood Titer ____ / ____ / ____

OR, Dose 1 ____ / ____ / ____

OR, Dose 2 ____ / ____ / ____

Signature of Physician: _____ Date: _____

Name of Physician (print or type): _____

Mailing Address: _____
(number and street) (city) (state) (ZIP)

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