2 HEALTH FORM

MOUNT VERNON NAZARENE UNIVERSITY
Life Changing

CONFIDENTIAL: Information is for use by the University Health Services and will be retained in a separate, confidential medical file. If you have additional questions, please call Student Health Services at (740) 392-6868, ext. 4632.

Beginning _____Term 20____

Name _____ ○ Male ○ Female
Last First Middle

Address _____ (_____) _____
Street or RFD City State Zip Code Telephone Number

Date of Birth _____ _____
Social Security Number

Medical Insurance Coverage ○ Yes ○ No _____
Carrier and Policy Number

Name of Parents, Guardian or Spouse _____ (_____) _____
Home Phone Number

Address _____ (_____) _____
Work Phone Number

In Case of Medical Emergency Contact:

Name _____ (_____) _____ (_____) _____
Home Phone Number Cell Phone Number

Address _____ (_____) _____
Work Phone Number

Relationship: ____Parent ____Guardian ____Spouse ____Brother ____Sister ____Other _____

Family Health History

Answer each item	yes	no	Relationship	Answer each item	yes	no	Relationship
Asthma, hay fever, hives	○	○		Heart trouble	○	○	
Cancer	○	○		High blood pressure	○	○	
Diabetes	○	○		Nervous/mental disorder	○	○	
Epilepsy	○	○		Stroke	○	○	
Mother living	○	○		Tuberculosis	○	○	
Father living	○	○	No. of brothers living	No. of sisters living	If dead, give relation and cause of death		

Personal Medical History Have you ever had, or have you now, any of the following? If "yes," give the details below.

Answer each item	yes	no		yes	no		yes	no		yes	no
Appendicitis	○	○	Ear trouble	○	○	Migraine headaches	○	○	Shortness of breath	○	○
Asthma	○	○	Epilepsy	○	○	Mononucleosis	○	○	Shoulder injury	○	○
Bone or joint deformity	○	○	Hay fever	○	○	Motion sickness	○	○	Skin disease	○	○
Chicken pox	○	○	Heart trouble	○	○	Mumps	○	○	Sinusitis	○	○
Chronic bronchitis	○	○	High/low blood pressure	○	○	Nervous/mental disorder	○	○	Stomach/intestinal disorder	○	○
Chronic cough	○	○	Jaundice/liver disease	○	○	Nose/throat trouble	○	○	Sugar/albumin in urine	○	○
Chronic/frequent colds	○	○	Kidney trouble	○	○	Pneumonia	○	○	Swollen/painful joints	○	○
Convulsions	○	○	Knee injury	○	○	Rheumatic fever	○	○	Thyroid condition	○	○
Diabetes	○	○	Lameness, paralysis, polio	○	○	Rubella	○	○	Tuberculosis	○	○
Diphtheria	○	○	Loss of limb or digit	○	○	Rupture/hernia	○	○	Wear corrective lenses	○	○
Dizziness/fainting spells	○	○	Measles	○	○	Scarlet fever	○	○	Whooping cough	○	○

Height _____ Weight _____

If you answered "yes" to any of the above, or have had other diseases, please give the details: _____

If allergic to serum or drugs, give the details: _____

List the types of surgery you have had: _____

List the types of medication you take regularly: _____

Please describe any psychiatric, psychological or emotional problems (anorexia, bulimia, suicide attempts, depression or other mental or nervous condition) Yes ___ No___ Describe, include dates and treatment received _____

Please continue on a separate sheet of paper, if needed. A release letter from attending physician is required.

Accommodations Needed

Answer each item	yes	no	If "yes," please give details.
1. to take allergy shots?	○	○	
2. psychiatric consultation or therapy?	○	○	
3. care for any existing injuries?	○	○	
4. assistance for physical disabilities?	○	○	if yes, please attach separate sheet describing in full
5. assistance for learning disabilities or AD/HD?	○	○	if yes, please attach separate sheet describing in full

The Office of Academic Support will need documentation of disability on items 4 and 5 that verifies eligibility for services requested.
(continued on reverse side)

Personal Immunization Record

Your health care provider should complete this section and sign below if possible, or attach documentation of immunizations given. Your health care provider should attach a statement if there are any unusual health problems that warrant special monitoring.

A. Tetanus Diphtheria -- booster must be within the last ten (10) years ..... _____/_____
Mo. Yr.

B. MMR (Measles, Mumps, Rubella) -- two doses required or individual vaccine as noted below in C, D and E
..... _____/_____ _____/_____
Mo. Yr. Mo. Yr.

C. Rubella (German Measles) -- check all that apply if given instead of MMR (clinical history is not acceptable)
1. Has report of positive immune titer. Specify date ..... _____/_____
Mo. Yr.
2. Immunized with live vaccine at 12 months after birth or later ..... _____/_____
Mo. Yr.

D. Measles (Rubeola) -- check all that apply if given instead of MMR.
1. Immunized with live measles vaccine. Two doses required if no MMR given ..... _____/_____ _____/_____
Mo. Yr. Mo. Yr.
2. Has report of positive immune titer. Specify date ..... _____/_____
Mo. Yr.
3. Had disease confirmed by physician's records ..... _____/_____
Mo. Yr.

E. Mumps -- check all that apply if given instead of MMR.
1. Immunized with live vaccine at 12 months after birth or later ..... _____/_____
Mo. Yr.
2. Has report of positive immune titer. Specify date ..... _____/_____
Mo. Yr.
3. Had disease confirmed by physician's records ..... _____/_____
Mo. Yr.

F. Tuberculosis (PPD required <u>regardless</u> of prior BCG inoculation)
PPD (Mantoux) within the past 6 months (tine or momovac not acceptable)
Result: Neg_____ Pos_____ mm induration (horizontal diameter)_____..... _____/_____
Mo. Yr.
If greater than 5 mm induration, chest x-ray required. X-ray result: Normal_____ Abnormal_____
Received BCG: Yes_____ No_____ If yes ..... _____/_____
Mo. Yr.

G. Polio
1. Completed primary series of polio immunization: Yes_____ No_____ Date of last booster ..... _____/_____
Mo. Yr.
2. Type of vaccine: Live (OPV)_____ Inactivated (IPV)_____ Enhanced Potency (EP-IPV)_____

H. Varicella Hist. of Disease Yes___ Date _____ No ___ Vaccinated…… _____/_____ _____/_____
Mo. Yr. Mo. Yr.

I. Meningococcal (recommended but not mandated) ..... _____/_____
Mo. Yr.

J. Hepatitis B (recommended but not mandated) …… ..... _____/_____ _____/_____ _____/_____
Mo. Yr. Mo. Yr. Mo. Yr.

Health Care Provider
Name_____ Address_____

Signature_____ Telephone (_____) _____

Statement of Affirmation and Consent

By completing this form, and signing it below, I agree to each of the following.

1. I affirm that the information provided on this form is accurate and complete. I understand that if I knowingly provide inaccurate or incomplete information (a) I release the University of any liability, and (b) providing inaccurate or incomplete information to MVNU can jeopardize my enrollment status and any concerns about disclosure will be reviewed by the Director of Residence Life.
2. I agree to submit to a complete physical, toxicological, and/or psychological evaluation as a condition of admission or continued enrollment, if requested in writing by Student Health Services or the Director of Residence Life.
3. I will report changes in medical conditions, medication or new medications immediately to Student Health Services as long as I am a residential student.
4. I give my permission to be treated by Student Health Services and/or the university physician. I understand that information on this form may be used by the Student Life staff in an emergency situation.
5. I give my permission for university officials to inform my designated "medical emergency contact" in an emergency situation.

_____ _____
Student's signature Date

_____ _____
Parent or Guardian's signature (if student is under age 18) Date

Revised 04-28-2009