



MORNINGSIDE COLLEGE

STUDENT HEALTH FORM

Drug Allergies: _____

HEALTH FORM including IMMUNIZATIONS IS REQUIRED FOR ALL STUDENTS (enrolled 9 or more hours) ENTERING AS A FRESHMAN, TRANSFER OR READMIT. Please fill out the front page and the top of the back page before going to your physician. Please PRINT all information.

This form must be received and immunization status approved before you are permitted to attend class.

Full name _____ Male/Female _____ Date of Birth ____/____/____
Last First Middle Initial Circle one M D Y

Home Address _____
Street Address City State Zip

Home Phone Number (____) _____ Student's Cell Phone Number (____) _____ Student's E-mail Address _____

Emergency Contact #1 _____
Full Name Relationship Phone #1 Phone #2

Emergency Contact #2 _____
Full Name Relationship Phone #1 Phone #2

Family Physician _____
Name Street Address City, State, Zip (____) _____
Phone Number

Date of entry to Morningside ____/____/____ Entering as: First-year ____ Transfer ____ Returning ____ Residence: On Campus ____ Commuter ____
Month/Year

Are you a veteran? Y / N

Family History

Age	State of Health	Occupation	Age, Cause of Death	What any relative currently has or has had:
Father				Tuberculosis _____
Mother				Diabetes _____
Brother				Kidney Disease _____
Brother				Heart Disease _____
				Asthma, Hay Fever _____
Sister				Cancer _____
Sister				High Blood Pressure _____
				Epilepsy, Convulsions _____

Personal History (Please answer all questions)

Have you had or are you concerned about?	Yes	No	Depression	Yes	No	Mumps	Yes	No	Tuberculosis	Yes	No
Alcohol use			Indigestion			Pneumonia			Urinary Tract Problems		
Asthma, Hay Fever			Gallbladder Trouble			Polio			Sexually Trsm Disease		
Back Problem			Gum/Tooth Trouble			Recent Wt. Gain/Loss			Weakness, Paralysis		
Cancer, cyst			Head Injury			Recurrent Colds			Worry, Nervousness		
Chemical Dependency			Heart Murmur			Recurrent Diarrhea			Female Students:		
Chest pain/pressure			Heart Palpitation			Recurrent Headaches			Irregular Periods		
Chronic Cough			High/Low Blood Pressure			Rheumatic Fever			Severe Cramps		
Diabetes			Jaundice			Scarlet Fever			Excessive Flow		
Dizziness/Fainting			Joint Injury/Disease			Shortness of Breath			Pregnancy		
Ear/Nose/Throat Trouble			Malaria			Sinusitis			Other Conditions		
Eating Disorder			Measles			Stomach/Intestinal Trble					
Epilepsy/Seizure Disorder			Measles (German)			Suicidal Thoughts					
Eye Trouble			Mononucleosis			Trouble Sleeping					
Anxiety/Panic Attacks											

Is there anything not covered above that you feel Health Services should be aware of? Please describe: _____

Medications currently taking (and reason): _____

	Yes	No	Please explain any "Yes" responses
Have you had any illness, injury, or surgery which required hospitalization?	_____	_____	_____
Have you consulted or been treated by clinic, physician, or other practitioners within the past five years?	_____	_____	_____
If so, have any of your activities been restricted in the past five years?	_____	_____	_____
Have you been rejected or discharged from military service because of physical, emotional or other reasons?	_____	_____	_____
Have you had any special difficulties with school or teachers?	_____	_____	_____
Have you ever experienced any personal or emotional difficulties which require professional attention?	_____	_____	_____

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 College to seek appropriate medical/surgical 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 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

____ Check here if you would like to receive a copy of our "Notice of Privacy Practices".

MUST BE COMPLETED BY A Health Care Provider PRIOR TO NEW-STUDENT REGISTRATION. IS REQUIRED FOR ALL STUDENTS BORN AFTER 1956.

REQUIRED IMMUNIZATIONS

(1) MENINGOCOCCAL IMMUNIZATION – VACCINE OR SIGNATURE REQUIRED

Please read the information at: www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf AND consult with your health care provider.

I have received 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 ____/____/____ OR MPSV4 Vaccine ____/____/____
(Menactra or Menveo) M D Y (Received within last 12 months) M D Y
Date of Booster ____/____/____
M D Y

Students should have documentation of having received this vaccine after their 16th birthday.
Students 21 and older must receive vaccine within 5 years of entry to Morningside College.

(2) M.M.R. (Measles, Mumps, Rubella) - 2 Doses Required** Dose #1 (15 mo. or after) ____/____/____ Dose #2 (5 yrs. or after) ____/____/____
M D Y M D Y
If given as separate doses please identify: Measles: #1 ____/____/____ #2 ____/____/____ Mumps: #1 ____/____/____ #2 ____/____/____ Rubella: ____/____/____
M D Y M D Y M D Y M D Y M D Y M D Y

** NOTE: If born prior to 1957 you are considered immune and require no further vaccination.

(3) Tetanus/Diphtheria/Pertussis: Primary Series Completed ____/____/____ TDAP Booster ____/____/____
M D Y M D Y

(4) Polio: Primary Series Completed ____/____/____
M D Y

(5) Tuberculosis Screening (Health Care Provider to Determine):

- Does the student have signs or symptoms of active tuberculosis disease? Yes ___ No ___ If No, proceed to #2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
- 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 member of a high-risk group.
- Tuberculin Skin Test Date Given: ____/____/____ Date Read: ____/____/____ Interpretation (based on mm of induration as well as risk factors):
M D Y M D Y Induration ____ mm Positive ___ Negative ___
- Chest x-ray (if above is positive) Results: Normal ___ Abnormal ___ Date of chest x-ray: ____/____/____
M D Y

RECOMMENDED IMMUNIZATIONS

(6) Hepatitis B Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
M D Y M D Y M D Y

(7) Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)
History of disease: Yes ___ No ___ Varicella antibody ____/____/____ Reactive ___ Non-reactive ___ Immunization: Dose #1 ____/____/____ Dose #2 ____/____/____
M D Y M D Y M D Y M D Y
(If age 13 years or older, Dose #2 given at least one month after first dose.)

(8) Quadrivalent Human Papilloma Vaccine (HPV) Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
M D Y M D Y M D Y

(9) Hepatitis A Dose #1 ____/____/____ Dose #2 ____/____/____
M D Y M D Y

Is the student now under treatment or medication for any medical or emotional condition? ___ Yes ___ No

Recommendations regarding the care of this student: _____

Physician's / Health Care Provider's Signature

Date

PLEASE PRINT: Health Care Provider's Name

Provider's Street Address

City, State

Zip

Phone Number (____) _____

Mail Completed Form To: Morningside College Student Health, 1501 Morningside Ave, Sioux City, IA 51106

The Morningside College experience cultivates a passion for life-long learning and a dedication to ethical leadership and civic responsibility.