

IMMUNIZATION RECORD

NAME _____ M ___ F ___
last first middle

Date of Birth: _____ / _____ / _____ Country of birth: _____
month day year

Date of Enrollment: _____ / _____ Undergraduate _____ Year: 1 2 3 4 OR Seminary _____
month year

Attach copy of previous immunization certificate if used as source of following vaccine dates.

To be completed and signed by Health Care Provider ALL DATES MUST HAVE MONTH, DAY AND YEAR

REQUIRED IMMUNIZATIONS	Vaccine Date	Vaccine Date	Alternate Proof of Immunity
MEASLES (rubeola): Two doses of live vaccine or two doses of MMR separated by at least one month are required. First dose must be January 1, 1968 or later, and on or after first birthday. MMR is preferred for second dose.	1	2	Date of Disease: M.D. Signature: <u>OR</u> Date of Titer: (Attach copy of result)
RUBELLA (German measles): Immunization with live vaccine must be June 19, 1969 or later, and on or after first birthday.	1		Date of Titer: (Attach copy of result)
MUMPS: Immunization with live vaccine must be January 1, 1968 or later, and on or after first birthday.	1		Date of Disease: M.D. Signature: <u>OR</u> Date of Titer: (Attach copy of result)
MMR (measles, mumps, rubella): Two doses of MMR, separated by more than one month eliminate the need for all of the above vaccinations. First dose must be May 1, 1971 or later, and on or after first birthday. (See measles section.)	1	2	
TETANUS/DIPHThERIA: Last dose must be within last 10 years. International students are required to show 3 dates of vaccination	1 DTP Series	2	3 Booster within last 10 years
____ If exempt from any of the above vaccines, attach a written, signed statement from a physician or a religious practitioner.			

Polio: Primary Series - Date Completed: _____ Last Booster: _____

Recommended Vaccines:

Hepatitis B: 1st _____ 2nd _____ 3rd _____
month / day / year month / day / year month / day / year

Menomune (meningitis): _____

Other Vaccines:

Tuberculosis : PPD test (Mantoux) within past year required UNLESS:
 positive PPD result* in past **OR** BCG vaccine given in past five years**.

PPD Date: _____ **Date Read:** _____ **Result in mm:** _____ **Signature:** _____

*If positive PPD result (current or in past): attach copy of chest x-ray result and record of INH prophylaxis.

**Chest x-ray required - attach copy of report.

Health Care Provider (Physician, Nurse, or Public Health Official) verifying above information:

Name (Print) _____ Signature _____ Date _____

Note: This form must be completed and returned to Health Services by all students. Athletic and nursing physicals are separate and additional, and are not a substitution for the Health Service form. PLEASE READ ALL PARTS OF THIS FORM AND THE ACCOMPANYING LETTER CAREFULLY.

All medical records and information are strictly confidential and will not be released without your consent.

MEDICAL HISTORY RECORD

PERSONAL HISTORY: Explain positive answers and make additional comments on back of form.

Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date
Allergies, seasonal				Eating Disorder				Pneumonia			
Anemia				Epilepsy				Pregnancy			
Arthritis				Eye Problem				Sinus Condition			
Asthma, chronic				Fracture/Sprain				Skin Disorders/Acne			
Asthma, exercise induced				Gall Bladder Disease				Stomach Disorders			
Back Problem				Head Injury				Strep Throat (freq)			
Bronchitis				Headaches (freq)				Sexually Trans. Diseases			
Cancer				Heart Condition/Murmur				Surgery			
Chicken Pox				Hepatitis				—Appendectomy			
Chronic Cough				High Blood Pressure				—Tonsillectomy			
Counseling				HIV/AIDS				—Other			
Depression (freq)				Kidney Problems				Thyroid Disorder			
Diabetes				Malaria				Tuberculosis			
Diarrhea (recurrent)				Menstrual Problems				Tumor/Cyst			
Dizzy Spells/Fainting				Mononucleosis				Urinary Tract Infection			
Ear, Nose, Throat Disorder				Paralysis				Weight gain or loss, recent			

HOSPITALIZATIONS: Reason Date

Has your physical activity been restricted during the past five years? No Yes
 (Give reasons and duration) _____

Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? No Yes
 (Give details) _____

Have you traveled or resided outside of the United States? No Yes
 If yes, where and when? _____

Date of last physical examination by a physician: _____

CURRENT HEALTH

LIST **ALLERGIES** TO DRUGS, FOODS, POLLEN, MOLDS, OTHER: _____

LIST **MEDICATIONS** TAKEN REGULARLY _____

Do you smoke cigarettes? No Yes Number per day _____
 Do you drink coffee? No Yes
 Do you drink alcohol? No Yes How much? _____
 Do you wear glasses? No Yes Contact Lenses? No Yes

FAMILY HISTORY

	Age	State of Health				Age of Death	Cause of Death
		Good	Fair	Poor	Deceased		
Father							
Mother							
Brothers							
and							
Sisters							
Spouse							
Children							

Have any of your blood relatives ever had any of these?	No	Yes	Relationship
Alcoholism			
Arthritis			
Asthma			
Cancer			
Diabetes			
Epilepsy			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Mental Illness			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			

I hereby certify to the best of my knowledge that the preceding information is complete and correct. I authorize North Park University to release the immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Signature of Student

Date

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

If examined by a physician:

Statement: I find the above student to be in good physical and emotional health and find no reason why he/she cannot participate in normal University activities.

Signature of Physician

Date

ADDITIONAL DATA

Health Insurance

Company/Organization: _____ Identification Number: _____

Student Insurance _____ Private _____ Insured's Name _____

Home Address

Number and Street *City/Town*

State or Province *Country* *Zip Code or Postal Code*

Telephone Number *Social Security Number (if available)*

Emergency Notification

Name *Relationship*

Address Number and Street

City/Town *State/ Province* *Country* *Zip Code/Postal Code*

Telephone: Home _____ Business _____

Family Physician: _____ Telephone: _____

DETAILS OF MEDICAL HISTORY FROM PAGE TWO