MORNINGSIDE COLLEGE
STUDENT 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 Morningside College 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**

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: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html 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 ___/___/___ (M D Y) **2 DOSES MENINGITIS B** ___/___/___ (M D Y) ___/___/___ (M D Y)

Date of Booster ___/___/___ (M D Y)

Students should have documentation of having received this vaccine after their 16th birthday.

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

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

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

(5) Tuberculosis Screening (Health Care Provider to Determine): THIS IS REQUIRED FOR ALL INTERNATIONAL STUDENTS

1. 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.
2. 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.*
3. Tuberculin Skin Test Date Given: ___/___/___ (M D Y) Date Read: ___/___/___ (M D Y) Interpretation(based on mm of induration as well as risk factors): Induration ______ mm Positive ____ Negative ____
4. 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 ___/___/___ (M D Y) Dose #2 ___/___/___ (M D Y) Dose #3 ___/___/___ (M D Y)

(7) Varicella (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___/___/___ (M D Y) Reactive ___ Non-reactive ___ Immunization: Dose #1___/___/___ (M D Y) Dose #2 ___/___/___ (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___/___/___ (M D Y) Dose #2 ___/___/___ (M D Y) Dose #3 ___/___/___ (M D Y)

(9) Hepatitis A Dose #1 ___/___/___ (M D Y) Dose #2 ___/___/___ (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**
This includes School Nurse, Registered Nurse, Doctor, ARNP, or PA-C

______________________ ______________________________ (______)__________

PLEASE PRINT: Health Care Provider's Name **Provider's Street Address** **City, State** **Zip** **Phone Number**

Mail Completed Original 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.

MORNINGSIDE COLLEGE
STUDENT HEALTH HISTORY

Today's Date ____________________

Name: ____ **Gender:** _______ **Birthdate:** ___________ **Email:** ___________________

Last First Middle Initial

Address:____ **Student's Phone:** _______________________

Street Address City State Zip Country

Individual Providing Health History-and relationship to student (If Not Student): ____

Emergency Contact #1: ______________________________________ **Phone:** ______________________ **Alternate #:** _________________________

Contact #2: ______________________________________ **Phone:** ______________________ **Alternate #:** _________________________

Current Health Care Provider Name: ____ **Phone:** ____________________________

Student History:

Are you a veteran? ❑ Yes ❑ No

Do you have an ongoing health concern? (Asthma, Diabetes, etc.) ❑ Yes ❑ No

If "Yes", please describe: ____

Do you have any allergies? (Include environmental and medical) ❑ Yes ❑ No

If "Yes", please list: ____

Has the allergy required emergency treatment? ❑ Yes ❑ No

If "Yes", please explain: ____

Have you had any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No

If "Yes", please describe: ____

Are there any current medical concerns/injuries? ❑ Yes ❑ No

❑ Head ________________________ ❑ Eyes __________________________ ❑ Nose ________________________

❑ Ears ________________________ ❑ Throat ________________________ ❑ Neck ________________________

❑ Chest ____ ❑ Respiratory ____

❑ Cardiovascular ____________________________________ ❑ Gastrointestinal _____________________________________

❑ Genitourinary ______________________________________ ❑ Neurological ____

❑ Musculoskeletal (include any past fractures, etc.) ____

❑ Emotional/Behavioral ____

Do you take any medications/supplements regularly? ❑ Yes ❑ No

If "Yes", please list medications taking: ____

If "Yes", please list supplements taking: ____

Family History:

Age	State of Health	Occupation	Age, Cause of Death
Mother			
Father			
Brother			
Brother			
Sister			
Sister			

What any relative currently has or has had:

Tuberculosis _______________________________
Diabetes ___________________________________
Kidney Disease _____________________________
Heart Disease ______________________________
Asthma, Hay Fever __________________________
Cancer ____________________________________
High Blood Pressure _________________________
Epilepsy, Convulsions ________________________

Social – Tell Us About:

Sleep: Average hours per night: ______________________________________ Nutrition: # Servings fruits/vegetables _______ /day

Exercise: Average minutes per day: __________________________________

Tobacco use: If "Yes" what and how often ______________________________ Alcohol Use: If "Yes" how often _______ /week

Recreational drugs: If "Yes", what and how often ____

Do you have an Advanced Medical Directive? If "Yes" contact name/relationship/phone ____

____

If "No", what are your wishes if unable or unwilling to speak for yourself medically? ____________________________________

____

Please list any additional concerns or information not covered. (Use separate page as needed.)

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