

MID-CONTINENT UNIVERSITY

STUDENT STATEMENT OF HEALTH *ALL MEDICAL RECORDS/INFORMATION ARE KEPT CONFIDENTIAL*

Student's Name: _____ Male _____ Female _____

State of Residence: _____ County of Residence: _____

Please answer following questions:

Any disease, impairment or abnormality of:

| Yes | No | Yes | No | Yes | No |
|-----|----------------------------------|-------------------|--------------------|----------------------------------|---------------------------------|
| | Allergies to Drugs | Measles (Rubella) | Chicken Pox | Abdominal Organ/Digestive System | Bones, Joints, Locomotor System |
| | Food Allergies | | Rheumatic Fever | Blood, Endocrine System | Varicose Veins |
| | Smoke Allergies | | Rubella | Brain, Nervous System | Ears or Hearing |
| | Pet Allergies | Scarlet Fever | Hepatitis A | Eyes or Vision | Genito-Urinary System |
| | Asthma | | Hepatitis B | Heart or Blood Vessels | Lungs, Respiratory System |
| | Appendicitis | Hernia | | Skin (Acne, etc) | TBC - Tuberculosis |
| | Cough (persistent, recurring) | Malaria | Seizure Disorder | Tonsils, Nose or Throat | |
| | Diabetes Mellitus | | Sleepwalking | | |
| | Enuresis | | Eating Disorder | | |
| | Goiter (Struma) | | Vertigo, Dizziness | | |
| | Headache (persistent, recurring) | | | | |
| | Learning or Speech Defect | | | | |
| | Parasites (intestinal, other) | | | | |

If "Yes" was checked for any of the above please provide full details and dates of treatment.

Has student ever been hospitalized? Yes No If Yes, please provide details and dates: _____

Is applicant presently taking any medication or injections? Yes No If Yes, please list all medications and the purpose for taking it (use back of form if necessary):

Has applicant ever consulted a psychologist, psychiatrist, neurologist or any other specialist for any of the following disorders:

____ Nervous or Emotional disorder ____ Sexual abuse
____ Eating disorder (anorexia nervosa, bulimia, etc.) ____ Emotional or physical abuse

If any were checked please explain: _____

Are there any restrictions on the student's participation in physical and/or sports activities? Yes No

If Yes, explain limitations: _____

Do you have any concerns that you would like to discuss with a member of our staff? Yes No

IMMUNIZATION RECORD

All students must provide proof of the following Immunizations:

| VACCINE | Dates each dose was given (month/day/year) | | | | |
|---|--|----------|----------|----------|----------|
| | 1st Dose | 2nd Dose | 3rd Dose | 4th Dose | 5th Dose |
| Polio (TOPV) | | | | | |
| DPT and/or TD (diphtheria - tetanus - pertussis whooping cough and/or tetanus and diphtheria only) | | | | | |
| *MMR (measles, mumps, rubella) | | | | | |
| Hepatitis B | | | | | |
| Hepatitis A (recommended but not required) | | | | | |
| Meningitis (recommended but not required) | | | | | |
| *If this immunization has not been given then give dates student may have had these diseases: Measles: _____ Mumps: _____ Rubella: _____ | | | | | |

In Case of Emergency Call:

Name: _____

Relationship to you: _____

1st contact #: _____ 2nd contact #: _____

If the above person cannot be reached, please contact:

Name: _____

Relationship to you: _____

1st Contact #: _____ 2nd Contact #: _____

I, the undersigned, certify that all important medical information has been noted on this form and that nothing relevant has been omitted.

Students' signature

Printed name

Address

Date