

MOUNT VERNON NAZARENE UNIVERSITY

Medical History Record

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, 740-392-6868 ext. 4632.

Beginning _____ Term 200 _____

Name _____
Last First Middle Male or Female? _____

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

Date of Birth _____
Social Security Number _____

Medical Insurance Coverage _____
Yes or No? Carrier and Policy Number

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

Address _____

In Case of Medical Emergency Contact:

Name _____
Home 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	yes	no		Heart trouble	yes	no	
Cancer	yes	no		High blood pressure	yes	no	
Diabetes	yes	no		Nervous/mental disorder	yes	no	
Epilepsy	yes	no		Stroke	yes	no	
Mother living	yes	no		Tuberculosis	yes	no	
Father living	yes	no	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	yes	no	Ear trouble	yes	no	Migraine headaches	yes	no
Asthma	yes	no	Epilepsy	yes	no	Mononucleosis	yes	no
Bone or joint deformity	yes	no	Hay fever	yes	no	Motion sickness	yes	no
Chicken pox	yes	no	Heart trouble	yes	no	Mumps	yes	no
Chronic bronchitis	yes	no	High/low blood pressure	yes	no	Nervous/mental disorder	yes	no
Chronic cough	yes	no	Jaundice/liver disease	yes	no	Nose/throat trouble	yes	no
Chronic/frequent colds	yes	no	Kidney trouble	yes	no	Pneumonia	yes	no
Convulsions	yes	no	Knee injury	yes	no	Rheumatic fever	yes	no
Diabetes	yes	no	Lameness, paralysis, polio	yes	no	Rubella	yes	no
Diphtheria	yes	no	Loss of limb or digit	yes	no	Rupture/hernia	yes	no
Dizziness/fainting spells	yes	no	Measles	yes	no	Scarlet fever	yes	no

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) on a separate sheet of paper. Please include dates and treatment received. 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?	yes	no	_____
2. psychiatric consultation or therapy?	yes	no	_____
3. care for any existing injuries?	yes	no	_____
4. assistance for physical disabilities?	yes	no	if yes, please attach separate sheet describing in full
5. assistance for learning disabilities or AD/HD?	yes	no	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 must complete this section and sign below. 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
1. Dose 1 given at 12 months after birth or later and Dose 2 after age 5 /
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 at 12 mos. after birth or later and after age 5. /
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 regardless 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 Rx of Disease Yes _____ No _____ Vaccinated /
Mo. Yr.
- I. Menomune (recommended but not mandated) /
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 Associate Dean of Student Development.
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 Associate Dean of Student Development.
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 Development 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