HEALTH HISTORY FORM

Please complete your health history form and return by August 1 to:

Student Health Center
P.O. Box 65
Baldwin City, Kansas 66006
785.594.8409

PLEASE INCLUDE:
- **COPY OF IMMUNIZATION RECORD**
- **COPY OF INSURANCE CARD**

To provide an environment in which student health is maintained, it is essential to have the information requested.

This form can be completed online at www.bakerU.edu/healthhistory.

Tell us about yourself

Name: *Please print.*

_____

Home Address: _____

_____
city state zip

Date of Birth _____

Home Phone # (____)_____

Cell Phone # of student (____)_____

SSN# _____

Date Entering Baker _____

Gender: ❍ Female ❍ Male

Marital Status:
❍ Single ❍ Married ❍ Widowed ❍ Divorced

Father's/Spouse's Name (if married) _____

Address _____
(if different from above)

Father's/Spouse's Cell _____

Father's/Spouse's Employer _____

Work Phone _____

Mother's/Spouse's Name _____

Address _____
(if different from above)

Mother's/Spouse's Cell _____

Mother's/Spouse's Employer _____

Work Phone _____

Person to Call in an Emergency _____

Relationship _____

Phone _____

Tell us about your family's health history

Relation	Age	If deceased, cause of death	Age at death
Father			
Mother			
Brothers			
Sisters			

Has any parent, brother, or sister had:

	YES	NO	if "yes" to any, please explain:
Asthma/hay fever	❍	❍	_____
Cancer	❍	❍	_____
Diabetes	❍	❍	_____
Heart trouble	❍	❍	_____
Convulsive disorder	❍	❍	_____
Alcoholism	❍	❍	_____
Hypertension	❍	❍	_____
Tuberculosis	❍	❍	_____

Insurance Information (Please attach a copy of Insurance Card)

Company _____

_____

Address _____

_____ Phone _____

Policy Holder _____

ID# _____

Group # _____

Policy Holders SSN # _____

❍ Traditional Plan ❍ PPO ❍ HMO ❍ Other

Physician's Name _____

Phone _____

Do you plan to participate in varsity sports? ❍ Yes ❍ No

Sport: _____

Student-athletes must complete additional information including a physical examination by a medical doctor before participation is granted by the Athletics Department. Forms are available on the sports medicine page of the BU Athletics website: **www.bakerU.edu/athletic-department/sports-medicine**.

International students are required to purchase their health insurance policy through Baker University when they enroll in classes.

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

For the (health) record

BAKER UNIVERSITY

1858

9/15/2014

Have you had...?

Yes	No	ACUTE INFECTIOUS DISEASES
❍	❍	Chicken Pox
❍	❍	Hepatitis
❍	❍	Infectious Mononucleosis (mono)
❍	❍	Pneumonia
❍	❍	Tonsillitis
❍	❍	Typhoid
❍	❍	Sexually Transmitted Diseases
❍	❍	Measles
❍	❍	Mumps
❍	❍	Other_____

Yes	No	OTHER DISEASES
❍	❍	Alcoholism/Drug Addiction
❍	❍	Anemia
❍	❍	Anorexia/Bulimia
❍	❍	Asthma
❍	❍	Cancer
❍	❍	Chronic Bronchitis
❍	❍	Chronic Skin Disease (eczema, psoriasis)
❍	❍	Convulsions, Seizures (epilepsy)
❍	❍	Dental Problems
❍	❍	Diabetes
❍	❍	Digestive Tract Disease (ulcer, colitis)
❍	❍	Gallbladder/Liver Disease
❍	❍	Glaucoma
❍	❍	Hay Fever
❍	❍	Heart Disease (rheumatic fever, murmur)
❍	❍	High Blood Pressure
❍	❍	Kidney or Bladder Disease
❍	❍	Malaria
❍	❍	Orthopedic Problems (knee, back)
❍	❍	Prolonged Depression or Anxiety
❍	❍	Speech, Hearing, Vision Problems
❍	❍	Severe Headache (migraine)
❍	❍	Thrombophlebitis
❍	❍	Thyroid or Endocrine Disturbance
❍	❍	Tuberculosis
❍	❍	Other: _____

Yes	No	OTHER HEALTH CARE HISTORY
❍	❍	Have you ever been hospitalized?
❍	❍	Have you had any surgical operations?
❍	❍	Are you under medical treatment?
❍	❍	Do you take any prescribed medicine or injection?
❍	❍	Do you have physical disabilities?
❍	❍	Do you need any special accommodations?
❍	❍	Have you been advised to seek psychological help?
❍	❍	Have you received psychological care?
❍	❍	Have you traveled outside the U.S.?
		Where? _____

Comment on **ALL** positive answers:_____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

ALLERGIES (medicine, food, other): _____

_____

This form is kept on file in the Student Health Center as a permanent part of your health record. **Please return form, copy of immunizations, and copy of insurance card to:** **Student Health Center**
P.O. Box 65
Baldwin City, Kansas 66006

Immunization Record (Please attach a copy of immunizations)

Immunity is required prior to registration. You must be in compliance with the immunization requirements to avoid a **HOLD** on your records at the Office of the University Registrar.

REQUIRED IMMUNIZATIONS:

Meningitis (Menveo or Menactra) - Mandatory _____ MM DD YY

Waiver of Meningococcal Meningitis Immunization (Does NOT receive Vaccination)
I have chosen NOT to be immunized. My signature below signifies that I have received and read the material provided to me on meningitis by Baker University.

_____
Signature of Student Required **(if waiving vaccine)** Date
(Parent/Guardian if student is under 18)

MMR (Measles, Mumps, Rubella)
- ❍ Dose 1: Immunized after 12 months of age _____ MM DD YY
- ❍ Dose 2: Immunized at 5 years or later _____ MM DD YY

Polio
- ❍ Completed primary series of polio immunization _____ MM DD YY

Tetanus-Diptheria (Td or Tdap)
- ❍ Completed primary series of tetanus-diptheria immunizations _____ MM DD YY
- ❍ Received tetanus-diptheria booster within the last 5-10 years _____ MM DD YY

Tuberculosis Screening

The state of Kansas requires each incoming university student (freshman and transfer) to complete the TB (tuberculosis) screening. Please complete the four questions below.

1. Have you ever had a **positive** TB (tuberculosis) skin test? Yes No
2. Have you lived with, or had close contact with anyone who was sick with tuberculosis? Yes No
3. Were you born in a country other than the United Sates? Yes No
   If yes, country_____
4. Have you traveled or lived 3 consecutive months in any country other than the United States? Yes No
   If yes, country_____

To review the at-risk countries go to **www.stoptb.org/countries/tbdata.asp**

RECOMMENDED IMMUNIZATIONS:

Hepatitis B
❍ #1 _____ MM DD YY ❍ #2 _____ MM DD YY ❍ #3 _____ MM DD YY

Hepatitis A
❍ #1 _____ MM DD YY ❍ #2 _____ MM DD YY

HPV Vaccine (Gardasil):
❍ #1 _____ MM DD YY ❍ #2 _____ MM DD YY ❍ #3 _____ MM DD YY

Varicella:
❍ #1 _____ MM DD YY ❍ #2 _____ MM DD YY ❍ Date of Disease _____ MM DD YY

Influenza: _____ MM DD YY

Religious/Philosophical Exemption to Immunization Requirement

I_____ or _____ object to the immunization of (circle) myself/the above named student to measles, rubella, mumps, diptheria/tetanus, polio. It is understood that exposure to these communicable diseases may cause disabilities and complications. In the event of a measles, rubella, mumps or meningitis outbreak on campus, the above named student will be excluded from campus.

The final step...

PERMISSION FOR MEDICAL TREATMENT

Permission is hereby given for treatment in the Baker University Student Health Center and for transportation by ambulance and hospitalization, if needed.

_____
Signature of Student Date
(Parent/Guardian if student is under 18)