health history 2009-10

OFFICE USE ONLY
ID # ________________

This self-report is held as confidential information in the Wellness Center and is not released without written consent. **This form must be completed and signed in its entirety, and submitted with a copy of a health insurance card and immunization records or a hold will be placed on your registration.**

Please Print

Name ____ ☐ Female ☐ Male
Last First Middle Initial

Date of Birth (MM/DD/YY) ______________________ Age ________

Local Address ______________________________ Phone ( ) ____________
Street City State Zip

Parent's Home Address ______________________________ Phone ( ) ____________
Street City State Zip

Person to Be Notified in Case of Emergency ______________ Relationship to Student ______________

Address ______________________________ Phone ( ) ____________
Street City State Zip

Current Health/Accident Insurance carrier **(please provide copy of card)** ______________ Policy # ______________

Personal Physician ______________ Address ______________________________
Street City State Zip

Family History

Age If deceased, cause

Father ______________________________

Mother ______________________________

Brother(s) ______________________________

Sister(s) ______________________________

Personal Health

Height ______________ Weight ______________

Please rate the following as: Excellent (1) Good (2) Poor (3) General Health ________ Eyesight ________ Hearing ________

Previous hospitalizations/surgeries/injuries: What, when and where?

____

List current medications:

____

Please check any of the following that you have had or currently have:

___ Anemia
___ Anorexia
___ Anxiety
___ Asthma
___ Back problems
___ Bulimia
___ Chickenpox
___ Convulsions
___ Depression
___ Diabetes
___ Eczema
___ Epilepsy
___ Fainting
___ Fevers
___ Food allergies
___ Hay fever
___ Headaches
___ Hearing loss
___ Heart murmer
___ Hypertension
___ Indigestion
___ Kidney trouble
___ Malaria
___ Mumps
___ Paralysis
___ Pneumonia
___ Rheumatic fever
___ Scarlet fever
___ Sexually transmitted disease
___ Sinus trouble
___ Swollen lymph glands
___ Thyroid trouble
___ Tuberculosis
___ Ulcer
___ Unconsciousness
___ Valley fever
___ Other ______________

The Wellness Center is a limited service provider. It is strongly advised that any student with a chronic physical or psychiatric condition establish a relationship with a local health provider prior to starting school.

POINT LOMA NAZARENE UNIVERSITY

California requires that you, as an incoming student, read, and check the appropriate box regarding the meningitis vaccination.

meningitis information

Meningococcal meningitis is a bacterial infection that can cause severe swelling of the brain and spinal cord. It is relatively rare and is often mistaken for a cold or the flu and ignored. It progresses quickly to a devastating disease with high potential for death. College-aged students primarily living on campus have a significantly higher risk of contracting meningococcal meningitis. The major risk factors are residence hall living, smoking and drinking. For this reason, the American College Health Association has adopted the guidelines adopted by the Advisory Committee of Immunization Practices (ACIP). These guidelines encourage information dissemination regarding this disease and vaccination availability to those who wish to reduce the risk of meningococcal disease.

Meningococcal vaccination is not to be confused with HIB vaccination (vaccine given during infancy to protect against specific meningitis associated with that age group).

meningitis vaccination

Check one below:

☐ I have decided to accept the meningitis vaccine from my family physician.
☐ I have decided to accept the meningitis vaccine from the PLNU Wellness Center during fall semester. Cash, check or placed on school bill.
☐ I have decided not to accept the meningitis vaccine.

Are you allergic to any drugs or serums? ___ Yes ___ No If yes, please specify which ones: ______________________________

Do you have any physical limitations? ____

required immunizations

Immunizations below are REQUIRED for students who are to be enrolled at PLNU.

Please provide a copy of your immunization records and also record dates below:

1. Verification of 2 doses of MMR (mumps, measles, rubella) for all entering students born after 1956
   - Date of first dose (at age 12-15 months or later) ____________________
   - Date of second dose (age 4-6 years or later) ____________________

2. Verification of last Tetanus-Diphtheria with Td or Tdap [current ACHA recommended for entering college is Tdap] within the past 10 years
   - Tetanus-Diphtheria booster (or booster with Tdap Tetanus-diphtheria-acellular pertussis) within the past 10 years (month/year):______/_____

3. Returning PLNU Student? Last year attended ____________

4. Attention **International Student**
   Please submit a current Tuberculosis screening (within past year) result along with your immunization record.

PLNU and the American College Health Association (ACHA) **recommend** the following vaccines be obtained prior to entering the university: Hepatitis B series, Tetravalent Meningococcal vaccine, Hepatitis A series, Varicella vaccine (for those without history or disease, or negative antibody titer), and a completed childhood Polio series. Immunization requirements and recommendations for students participating in international travel vary depending on destination.

The above requirements and information are based on ACHA, Advisory Committee on Immunization Practices (ACIP), and Department of Health Services State of California.

I hereby certify that I have reviewed/responded to the meningitis information and that this self-report health form is valid.

____ ____________________

Student Signature (Co-signed by parent if student is less than 18 years of age) Date

Please visit **www.pointloma.edu/consent**, and download the "Consent to Treat a Minor" form for permission to treat in the Wellness Center.

OFFICE STAFF USE ONLY

Form complete & reviewed by ____________________ Date ____________________

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