CONFIDENTIAL HEALTH QUESTIONNAIRE AND IMMUNIZATION RECORDS

Name ____ Age _______ Birth Date ______________
First Middle Last

Permanent Address ____
Street City State Zip code

Home Phone: _______________ Cell Phone: ______________ Email:____________________________

Name of Parent/Guardian ________________________________ Parent/Guardian Phone #: ______________

Name of Parent / Guardian: _________________________ Parent / Guardian Phone #:___________________

In case of emergency, notify: ____

Day Phone # (____)__________________________ Night phone #: (_____)__________________________

Immunization Requirements and Tuberculosis Questionnaire:
Please provide a copy of your immunization records

Required Immunizations:

Meningococcal Tetravalent meningitis vaccine……………………………….….. Date ____/____/____
M D Y

M.M.R. (Measles, Mumps, Rubella) (Two doses required)

1. Dose 1 given at age 12-15 months or later…………………………………………… #1____/____
M Y
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose..……… #2____/____
M Y

Tuberculosis (TB) Risk Questionnaire:

Please check all that apply

- ☐ Had a positive skin test or blood test for Tuberculosis infection.
- ☐ Been offered, or taken, medication for Tuberculosis.
- ☐ Been employed, volunteered, or resided in a homeless shelter, substance abuse program, health care facility, or correctional facility?
- ☐ Had close contact with someone known to have active Tuberculosis.
- ☐ Have a history of IV drug use, unexplained fevers, night sweats, fatigue, loss of appetite, prolonged cough, coughing up blood, or unintentional loss of more than 10% of your weight.
- ☐ Born, lived, or spent more than one consecutive month outside of the continental U.S.
  - If so, where? ____
- ☐ Have a history of any condition, or prolonged use of any medications that could affect your immune system.

Health Care Provider

*Health Insurance Co.: ___________________________ Policy #: ______________________________

Health Care Provider: ____
Name City/State Phone #

Are there any conditions affecting you which would be important for us to know? If so, please explain. ____________

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-OVER-

Recommended Immunizations:

Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody)

1. Immunization

   Dose #1____/____ (M Y) Dose #2____/____ (M Y) Dose #3____/____ (M Y) or

2. Hepatitis B surface antibody Date ____/____ (M Y)

   Result Reactive______ Non-reactive______

Tetanus-Diptheria (Primary series with DTaP or DTP and booster with Td in the last ten years)

#1 ____/____ (M Y) #2 ____/____ (M Y) #3 ____/____ (M Y) #4 ____/____ (M Y)

Tetanus-Diphtheria (Td) booster within the last ten years …………………………… ____/____ (M Y)

Varicella (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement)

1. History of Disease Yes _____ No _____ or Birth in U.S. before 1980 Yes _____ No _____
2. Varicella antibody: Result: Reactive _______ Non-reactive ______ …………………….. ____/____ (M Y)
3. Immunization

   Dose #1 ____/____ (M Y) Dose#2 ____/____ (M Y)

Family History			
Relation	Age	Living?	If in poor health or deceased, list cause.
Father			
Mother			
Sister(s)			
Brother(s)			

Has anyone in your family had any of the following?

___ Stroke ___ Seizures ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Depression/Anxiety __ Heart Disease

Which, if any, of the following have you had?

___Asthma ___Thyroid Disease ___Cancer ___Depression/Anxiety
___Diphtheria ___Hay Fever ___Malaria ___Rheumatic Fever
___ADHD ___Pneumonia ___Diabetes ___Ulcers
___Kidney Disease ___Ear Infections ___Tuberculosis ___Sinusitis
___Scarlet Fever ___Heart Trouble ___Chest Pains ___Jaundice
___Epilepsy/Seizures ___High Blood Pressure ___Other ____

Are you a _____Veteran or ____do you have a military service-related disability?

Are you allergic to any drugs? _____________________ Other Allergies _______________________________________

Are you taking medication on a regular basis? ______ If so what medication/s: ___________________________________

Please list any surgeries that you have had and the year of each: _______________________________________

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**Westminster College does not offer student health insurance, but we can refer you to an outside organization that does. You can get information from the Office of Student Life at 801-832-2230 or at www.acsa.com*