IMMUNIZATION RECORDS

This form must be completed and returned to Student Health Services prior to registration by all new freshmen, transfer, and returning former students.

PERSONAL DATA: **SOCIAL SECURITY #**_____

NAME _____ BIRTHDATE _____
Last First Middle

CURRENT ADDRESS _____
Street City State Zip Code

TERM YOU PLAN TO ENTER BHSU: ❑ Fall 20 _____ ❑ Spring 20 _____

IN CASE OF EMERGENCY NOTIFY:

Name _____ Relationship _____
Street or PO Box _____ Telephone _____
City _____ State & Zip Code _____

---

1. REQUIRED OF ALL ADMITTED STUDENTS BORN AFTER 1956: All new incoming freshmen, transfers, and returning former students born after 1956, must document their immune status for MMR. Proof of two doses of MMR vaccine or of the presence of an immune antibody titer against MMR will be required.

A. MMR (Measles, Mumps & Rubella)
   1. Date of First Immunization (mo/yr) _____
   2. Date of Second Immunization (mo/yr) _____

---

2. RECOMMENDED FOR ALL ADMITTED STUDENTS: The following is requested for further immunizations. Documented immunity to Hepatitis B, Diphtheria, Tetanus, Poliomyelitis, & Meningococcus is recommended, but not required.

A. DIPHTHERIA AND TETANUS (DT or TD): Date of Last Immunization (mo/yr)_____

B. POLIO (OPV or IPV): Date of Last Immunization (mo/yr)_____

C. TUBERCULIN SKIN TEST: Date _____ Result _____
*Date of chest X-ray_____
Result of chest X-ray _____

D. HEPATITIS B: Date of First Immunization (mo/yr)_____
Date of Second Immunization (mo/yr) _____
Date of Third Immunization (mo/yr) _____

E. MENINGOCOCCUS (For all freshmen living in dorms): Date of Last Immunization (mo/yr)_____

TO THE HEALTH CARE PROVIDER: This student is applying for admission to a South Dakota state university. Medical information supplied is intended for use by the institutional medical staff for purposes of providing well-informed care to the student and to protect the public health. Incomplete records may delay the student's registration. Please review the requirements, administer needed immunizations, and sign below to validate the information recorded above.

*Signed _____ Date: _____
(Physician, Nurse, or Health Authority)

*Copies of certificates showing immune status may be substituted for this signature

MEDICAL HISTORY

Important Notice: This information is used to provide vital information to Student Health Services. Complete this form and return to **STUDENT HEALTH SERVICES**, Black Hills State University, 1200 University Street Unit 9429, Spearfish, SD 57799-9429, **PRIOR TO REGISTRATION**, or Fax it to (605) 642-6194.

(Please print in ink or type)

PERSONAL HEALTH HISTORY

Allergies: Yes ❑ No ❑ Please circle those to which you are allergic: Penicillin Sulfa Aspirin Codeine
Other drugs (specify)_____Environment _____
I take allergy shots (specify allergens and frequency)_____
MEDICAL OR HEALTH CONCERNS – Please check conditions/diseases you have had. If none apply, check this box. ❑

	Chicken Pox		Hearing Problems		Hypertension		Eczema		Whooping Cough
	Learning Disorder		Heart Murmur		Hives		Arthritis		Rheumatic Fever
	Birth Defects (Specify)		Tonsils Removed Yes No		Sexually Transmitted (Specify)		Mitral Valve Prolapse		Attention Deficit Disorder (ADD)
	Hepatitis A		Hepatitis B		Abnormal Pap Smear		Migraines		Tachycardia
	Organ Transplant (Specify)		Urinary Tract Infections		Eating Disorder (Specify)		Inflammatory Bowel Disease		Irritable Bowel Syndrome
	HIV		Ear Infections		Ulcers		Diabetes		Menstrual Problems
	Mononucleosis		Sinusitis		Thyroid Disease		Kidney Stones		Genital Problems
	Cerebral Palsy		Tuberculosis		Acne		Back Problems		Vertigo
	Epilepsy (Seizures)		Asthma		Pneumonia		Breast Problems		Other

A. Do you have an illness or condition, not listed above, for which you are now being treated? If yes, specify.

_____

B. Chronic/long-term/on-going conditions.

_____

C. List date(s) and reasons for any hospitalizations.

_____

D. Have you had severe symptoms and/or treatment for insomnia, anxiety, depression, suicidal thoughts or mental or emotional disorders? Explain and give dates and medication.

_____

E. Are you currently taking over-the-counter or prescription drugs (include birth control pills)? Please list the drugs and reason for taking.

_____

FAMILY HEALTH HISTORY

Has any family member had any of the following? If none apply check this box. ❑
Indicate F=Father M=Mother B=Brother S=Sister

	Alcoholism		Migraine		Diabetes		Sudden Death		Hypertension
	Substance Abuse		Cancer		Sever Obesity		Heart Disease		Other_____
	Allergy		Kidney Disease		Emotional Illness		Tuberculosis		Other_____

CONSENT FOR HOSPITALIZATION OR MEDICAL TREATMENT:

I, _____ , do hereby voluntarily consent to such diagnostic procedures and hospital care and to such medical, surgical, or x-ray treatment by university health care providers as is necessary in their judgment.

I understand that before surgical procedures or special treatment is done, the Health Services Provider will obtain my consent.

Signed _____ Date _____

(Signature of Parent, guardian, spouse, or self, if independent)