*Student's name _____

*Date of Birth ___/___/____

Immunization Requirements

Immunizations are needed for students born after 1956 that are taking 6 or more credit hours

Records indicating proof of the immunizations listed below must be submitted with this health form.

Attach photocopy of signed or stamped physician or clinic records and /or school immunization certificate listing dates of immunizations.

Measles, Mumps and Rubella

1.) Official immunization records signed or stamped by Health Provider *or*
High School immunization records documenting 2 MMR's ****1st MMR MUST BE GIVEN AFTER 1ST BIRTHDAY****

2.) Serological Titer to prove immunity of MMR

** Please note: **TITER REPORT MUST BE SIGNED BY A HEALTH PROVIDER ****

****

Meningococcal Meningitis Vaccine

1) Official documentation of Meningococcal Meningitis Vaccine **** MUST HAVE BEEN RECEVED IN THE PAST 10 YEARS****

Optional: Meningitis Waiver

I HAVE REVIEWED THE FACT SHEET REGARDING MENINGOCOCCAL DISEASE. I AM FULLY AWARE OF THE RISKS ASSOCIATED WITH THIS DISEASE AND OF THE AVALABILITY AND EFFECTIVEMESS OF THE VACCINE. I DECLINE THE VACCINE AT THIS TIME.

Signature of Student _____ Date _____/_____/_____ (parent or guardian signature if under age of 18)

Tetanus and PPD are Optional

Last Tetanus Vaccine Date___/___/_____

Td Booster needs repeated every 10 years

PPD Date within 1 Year ___/___/_____ ( ) positive ( ) negative

Results to be read within 48-72 hours _____mm induration

Date BCG given____/____/_____

Communicable Disease History

Please indicate if you have had any of the following diseases and at what age you had the disease.

NO	UNCERTAIN	YES	AGE
( )	( )	( )	_____Measles (9 day)
( )	( )	( )	_____German Measles
( )	( )	( )	____ Rubella (3 day)
( )	( )	( )	_____ Mumps
( )	( )	( )	_____ Chickenpox
( )	( )	( )	_____ Whooping Cough
( )	( )	( )	_____ Diphtheria
( )	( )	( )	_____ Polio
( )	( )	( )	_____ Tuberculosis

Family Health History

Please indicate if any of your blood relatives (parents, brothers, sisters, children, grandparents, have had any of the following:

	NO	YES	RELATIONSHIPS
Diabetes	( )	( )	_____
Bleeding Disorder	( )	( )	_____
Seizure Disorder	( )	( )	_____
High Blood Pressure	( )	( )	_____
Heart Attack	( )	( )	_____
Stroke	( )	( )	_____
Asthma	( )	( )	_____
Thyroid problems	( )	( )	_____
High Cholesterol	( )	( )	_____
Gout	( )	( )	_____
Obesity	( )	( )	_____
Alcoholism/Drug	( )	( )	_____
Cancer	( )	( )	_____
Allergies	( )	( )	_____
Anxiety/Depression	( )	( )	_____
Other Mental Illnesses	( )	( )	_____