

PLEASE COMPLETE AND PRINT ALL INFORMATION

Name _____ **Today's date:** _____
 Last First Middle

Birth Date _____ **Student ID** _____

Local address _____ **Local phone ()** _____

Permanent mailing address _____ **Phone ()** _____

Emergency Contact

Name _____

Relationship _____

Address _____

Phone/Fax _____

Please list any medications you take:

Please list any allergic or adverse reactions:

Family Health History (blood relatives)

Please check all that apply YES Relationship

Diabetes _____

High blood pressure _____

Stroke _____

Cancer (type:) _____

Heart attack before age 60 _____

High cholesterol _____

Other significant conditions _____

Have you ever had or do you currently have: Please check all that apply.

	Yes	Year		Yes	Year		Yes	Year
Serious skin disease			Used laxatives, diuretics or self-induced vomiting to control weight			Serious depression		
Tumor or cancer			Anorexia nervosa			Excessive worry or anxiety		
Eye trouble other than need for glasses			Binge eating/Purging (bulimia)			Have you tried to commit suicide?		
Hearing loss			Ulcer (duodenal or stomach)			Psychiatric hospitalization		
Ear, nose & throat trouble			Nausea/vomiting/diarrhea			DES exposure in utero		
Sinusitis			Jaundice & hepatitis			Sleep disturbance		
Thyroid trouble			Mononucleosis			Do you use tobacco?		
Hay fever			Gall bladder trouble/gallstones			Alcohol/other drug problems		
Shortness of breath			Hernia			For Men		
Asthma			Rectal disease/hemorrhoid			Sexually transmitted disease		
Pneumonia			Kidney stone			Testicular problem		
Chronic cough			Swollen or painful joint			Do you practice testicular exam?		
Tuberculosis			Arthritis, rheumatism or bursitis			For Women		
Positive tuberculin skin test			Neck or back problems			Menstrual problems		
High blood pressure			Concussion (severe head injury)			Breast problems		
Rheumatic fever			Frequent or severe headaches			Do you practice breast exam?		
Heart trouble			Dizziness or faulty speech			Pelvic inflammatory disease		
Abdominal pain			Epilepsy			Sexually transmitted disease		
Diabetes			Anemia or blood disorder			Ovarian cysts		
						Abnormal pap smear		

Please comment on any yes responses. (List dates/location of any hospitalizations, surgeries, severe injuries.) Do you have other health concerns that we should know about? Attach another sheet if necessary. Please remember to fill out other side.

Student Signature _____

Date: _____

Record of Required Immunizations

Proof of immunization is mandatory for all students living in university housing at UAF. This form signed by a clinician or a copy of your medical record of immunizations must be completed and returned to the Student Health and Counseling Center before you enroll.

If you don't have your immunization record, try getting it from your high school or previous college, your local health department if you received immunizations there, your military immunization record, your pediatrician's office, or from your parents.

REQUIRED immunizations are indicated by an asterisk (*).

Any student living in university housing must have ALL of the * items (Board of Regents policy 09.11.010).

A copy of your official immunization record is acceptable in lieu of completing this form; please attach.

	Date	Results	
Tuberculosis (PPD) Skin Test *			Date must be <u>within one year</u> of UAF admission. If TB test is positive a chest X-ray is required.
Tetanus, Diphtheria, Pertussis— primary series completed	Month	Year	If serious doubt exists about the completion of a primary 3 dose series, 2 doses of 0.5 ml of combined (Td) toxoids should be given one month apart, followed by a third dose in 6–12 months.
Tetanus, Diphtheria Booster or Tetanus, Diphtheria, and Pertusis Booster *	Month	Year	Must be <u>within the past 10 years</u> .
Poliomyelitis series completed	Month	Year	
Measles, Mumps, Rubella (MMR) 1st dose *	Month	Year	Recommended for students born after 1956. Laboratory evidence of immunity is acceptable.
Measles, Mumps, Rubella (MMR) 2nd dose *	Month	Year	A second dose is highly recommended. Laboratory evidence of immunity is acceptable.
Other:	Month	Year	Other immunizations recommended by the American College Health Association include: <ul style="list-style-type: none"> • Varicella (chicken pox) for persons without a history of the disease or without a history of vaccination or positive antibody titer • Hepatitis A (series of 2 vaccines) • Hepatitis B (series of 3 vaccines) • Meningococcal (for freshman students, especially those living in dormitories) • Human papilloma virus (HPV) (for females ages 11-26; series of 3 vaccines)

Certification of Dates of Immunization and Freedom from Active Tuberculosis

Signature of clinician or public health official _____ Date _____

Printed name and address _____

Student signature _____ Date _____

If student is under 18 years of age:

I hereby give the Student Health and Counseling Center permission to give my son/daughter medical treatment, counseling and/or appropriate immunizations.

Parent or guardian signature _____ Date _____