BETHEL UNIVERSITY

3900 Bethel Drive, St. Paul, MN 55112

HEALTH HISTORY

All students are required to complete pages 1 and 2 of this form and return it promptly to the Health Services. This Health History is restricted to use by the Health Services and will not be released to anyone without your consent.

Name______________________ ______________ ______________________ ________________________
Last First Middle Date of College Entry

Home Address ___________________________________ ____________________ _________ __________
Street Town or City State Zip

(_______) ___________________________________ (_______) ___________________________________
Home Phone Number Cell Phone Number

________ ____________________ ____________________ ______ ______ ________ ________
Date of Birth Place of Birth Social Security Number Sex Marital Status Height Weight

IMMUNIZATION RECORD FOR STUDENTS ATTENDING POST-SECONDARY SCHOOLS AS REQUIRED BY MINNESOTA LAW

Minnesota law (MS 135A.14) requires that all students born after 1956 and enrolled in public or private post-secondary schools in Minnesota be immunized against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions (see below*). This form is designed to provide the school with the information required by the law and will be available for review by the Minnesota Department of Health and the local community health board.

All dates must include month, day (if available), and year.

		Mo/Day/Year	Mo/Day/Year	Mo/Day/Year
Required:	**Tetanus/Diphtheria (Td)** Within the past 10 years - required by MN law			
	Measles/Mumps/Rubella (MMR) Two doses after 12 months - required by MN law			
Recommended: Discuss with your physician	**Hepatitis A** A two-dose series is recommended for certain persons at increased risk and others wishing to obtain immunity, especially international travelers.			
	Hepatitis B Persons at increased risk should have completed a three-dose series.			
	Poliomyelitis Recommended for students under 18 years and some international travelers.			
	Meningococcal Vaccine Recommended for students under 25 years living in dorms.			
	Varicella Vaccine Recommended for students who have not had chicken pox disease.			

For the student: I certify that the above information is a true and accurate statement of the dates on which I received the immunizations.

Student's signature ________________________________ Date _______________

* If you haven't been immunized and wish to file an exemption to any or all of the required immunizations, you must complete the following. Please note that a physician's signature is needed for a medical exemption, and a notary signature is needed for a conscientious exemption.

MEDICAL EXEMPTION:

The student named above does not have one or more of the required immunizations because he or she has (check all that apply):

❏ a medical problem that precludes the ____________________ vaccine(s).

❏ a history of ___________________________ disease.

❏ laboratory evidence of immunity against _______________.

Physician's signature ____________________________

Date ____

CONSCIENTIOUS EXEMPTION:

I hereby certify by notarization that immunization against __________ _____ is contrary to my conscientiously held beliefs.

Signature of student: ____________________________

Date ____

Subscribed and sworn before me on the _______ day of ___________, 20____.

Signature of notary ________________________________

The student is responsible for any medical or hospital expenses beyond the on-campus facilities, including transportation costs.

Family Doctor ____________________ Address ____________________

Are you presently covered by health or accident insurance? Yes____ No____ If yes, company ____________________

Policy Number ____________________

A doctor's examination within six months of enrollment is **required only** if you plan:
❑ Participation in intercollegiate athletics. ❑ Exemption from physical education courses.

❑ An exam is encouraged for a student with a chronic or serious condition that presents any potential need for health care.

Check the appropriate box above to receive an exam form if you need a doctor's exam for one of these reasons.

FAMILY HISTORY

____________________ Name of Parent, Guardian, or Next of Kin ____________ Relationship ____________ Town or City ______ State

____________________ Home Phone ____________________ Work Phone

Give age and present health of parents and siblings. (If deceased, give age at death and cause of death.)

Father ____________________ Mother ____________________

Sister(s) ____________________ Brother(s) ____________________

Is there a history of tuberculosis, diabetes, epilepsy, cancer, and/or mental illness (e.g., depression, bipolar, schizophrenia) in your immediate family?

____________________ Relationship ____________________

PERSONAL MEDICAL HISTORY

Underline the following illnesses or injuries that you have had. State age.

Measles (Red) __________ Chicken Pox __________ Heart Trouble __________ Tuberculosis __________

Measles (German) __________ Diabetes __________ Kidney Trouble __________ Arthritis __________

Mumps __________ Seizures __________ Asthma __________ Eating Disorder __________

List any other chronic or serious illness(es) you have had. ____________________

List and give date of any operation(s) you have had. ____________________

Do you have a permanent physical disability? ________ If so, what? ____________________

Have you received treatment or counseling more than three times for psychological or emotional problems: (When, what reason?)

____

____

Have you ever had an allergic reaction to any kind of drug? (State name of drug.) ____________________

Have you ever had an allergic reaction to any food, insect bite, etc.? (Name, explain.) ____________________

Are you presently taking any medicine? (Name, dosage.) ____________________

Have you ever been hospitalized? (Reason, date.) ____________________

Have you ever had a head injury or loss of consciousness? (Date, extent.) ____________________

Have you ever been told by a physician that you have anything wrong with your heart? _______ If so, what? ____________________

____

General condition of health in your opinion: Good _________ Fair _________ Poor _________

Is there any apparent reason for restriction of activity? If so, why? ____________________

REMARKS OR ADDITIONAL INFORMATION: