STUDENT HEALTH HISTORY FORM

LAST NAME **FIRST NAME** **MIDDLE NAME** **STUDENT F00#** **CELL #**

HOME ADDRESS **CITY** **STATE** **ZIPCODE**

DATE OF BIRTH (MM/DD/YYYY): **EMAIL:** **GENDER:** ☐ **MALE** ☐ **FEMALE**

NAME OF EMERGENCY CONTACT PERSON **RELATIONSHIP** **PHONE NUMBER (WITH AREA CODE)**

ALLERGIES (Check where applicable)

☐ No Known Allergies ☐ Environmental/Seasonal ☐ Medications: (please list below)

Medication	Reaction

☐ Other: _____

FAMILY HISTORY (Parents, Siblings, Grandparents)

☐ Alcoholism/Drug Addiction	☐ Blood Disorder	☐ Epilepsy	☐ High Cholesterol	☐ Sudden Death
☐ Anemia	☐ Cancer	☐ Glaucoma	☐ Mental Illness	☐ Suicide
☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Migraines	☐ Thyroid disease
☐ Asthma	☐ Depression	☐ High Blood Pressure	☐ Stroke	☐ Tuberculosis

☐ Other: _____

PERSONAL HISTORY (Check where applicable)

☐ ADHD	☐ Cardiac Abnormalities	☐ Head Injury with Concussion or Loss of Consciousness	☐ Menstrual Problems
☐ Alcoholism	☐ Chronic Cough	☐ Headache	☐ Mental Illness
☐ Anemia	☐ Chronic Kidney Disease	☐ Heart Condition	☐ Migraines
☐ Anxiety	☐ Constipation	☐ Hepatitis	☐ Mononucleosis
☐ Arthritis	☐ Depression	☐ High Cholesterol	☐ Rheumatoid Disease
☐ Asthma	☐ Diabetes	☐ Hypertension/High Blood Pressure	☐ Seizures/Epilepsy
☐ Back/Neck Problems	☐ Drug Abuse	☐ Insomnia	☐ Sexually Transmitted Infection
☐ Bladder/Kidney Infection	☐ Eating Disorder		☐ Sickle Cell Disease
☐ Blood Disorder/Transfusion	☐ Fainting/Dizziness		☐ Thyroid Disease
☐ Cancer	☐ Gastrointestinal Problems		☐ Tuberculosis

Other: _____

Please describe any past serious illness/injury, surgeries or hospitalizations: _____

_____

_____

CURRENT MEDICATIONS (Check and list where applicable)

☐ None ☐ Over the Counter: _____ ☐ Vitamins & Supplements: _____

☐ Prescriptions:

Drug Name	Dose & Frequency

IMMUNIZATION HISTORY

Tetanus-Diphtheria – Pertussis booster (Tdap) Booster within last 10 years Date: _____	**Varicella** (Chicken Pox) Dates: #1: _____ #2: _____
Meningococcal vaccine after age 16 Date: _____	**Hepatitis B** Dates: #1: _____ #2: _____ #3: _____
MMR (Measles, Mumps and Rubella) Date: #1: _____ #2: _____	**HPV** Dates: #1: _____ #2: _____ #3: _____

*****TUBERCULOSIS (TB) SCREENING REQUIREMENT*****

Have you ever been in close contact with anyone known or suspected to have active TB?

☐Yes ☐No

Have you lived **OR** had extensive travel to a high prevalence area, including **Africa, Asia, Central or South America, Eastern Europe, the Caribbean Islands, the Pacific Islands, or the Middle East?**

☐Yes ☐No What country are you from? _____

If you responded **YES** to either question, TB Screening is **REQUIRED**. Options are as follows:

1. Schedule an appointment at the Student Health Center for a TB Screening Test. Call 262-243-4574.
2. Attach documentation of negative TB test within the last 6 months. If you are from a high prevalence area, we will only accept a TB blood test (IGRA).
3. Attach documentation of prior treatment of latent or active TB.

Failure to comply with this requirement may result in a Student Life Hold being placed on your account!

AUTHORIZATION FOR MEDICAL TREATMENT

For All Students: By providing my signature below, I verify that the information on this form is accurate and true. I give permission to the staff at Concordia University of Wisconsin to administer any medical care that might be deemed necessary for my health and wellbeing. I understand that this information is strictly confidential and will not be released to anyone without my written consent, except in an emergency or by Court Order. By providing my signature below, I grant permission for emergency treatment, transportation to and/or hospitalization at an accredited hospital when necessary.

_____

SIGNATURE OF STUDENT IF 18 OR OLDER **DATE**

_____

SIGNATURE OF PARENT/GUARDIAN IF STUDENT IS UNDER 18 YEARS OF AGE **DATE**

Submit completed form to:

Concordia University Student Health Center
12800 N. Lake Shore Dr. – AL113
Mequon, WI 53097

Phone: (262) 243-4574 / Fax: (262) 243-3574