# MORNINGSIDE UNIVERSITY

## STUDENT IMMUNIZATION RECORD

Full Name _____ Date of Birth ____/____/____

**EMERGENCY TREATMENT CONSENT:** In case of an accident or emergency in which I may be unable to direct my own medical care, I authorize Morningside University to seek appropriate care for me until those identified as emergency contact persons can be notified. I hereby state that the above information is true and I give permission for Morningside University Health Services to release information to health care providers and facilities who are included in my treatment. **If under 18, must be signed by both student and parent and/or guardian.**

_____

Student Signature Parent/Guardian Signature Date

**MUST BE COMPLETED BY A Health Care Provider PRIOR TO NEW STUDENT REGISTRATION. REQUIRED FOR ALL STUDENTS BORN AFTER 1956.**

## REQUIRED IMMUNIZATIONS

**(1) MENINGOCOCCAL IMMUNIZATION - VACCINE OR SIGNATURE REQUIRED**
Please read the information at www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html AND consult with your health care provider.
I have received information about meningococcal disease and choose not to receive the vaccine at this time:

Signature required if not receiving vaccine: _____ Date _____

**I HAVE RECEIVED VACCINE: (Preferred) MCV4 Vaccine** ____/____/____ **2 DOSES MENINGITIS B** ____/____/____ ____/____/____

**Date of Booster:** ____/____/____ Students should have documentation of having received this vaccine after their 16th birthday.

**(2) M.M.R.** (Measles, Mumps, Rubella) **- 2 Doses Required Dose 1** (15 mo. or after) ____/____/____ **Dose #2** (5 yrs. or after) ____/____/____
If given as separate doses please identify: **Measles #1** ____/____/____ **#2** ____/____/____
**Mumps #1** ____/____/____ **#2** ____/____/____ **Rubella** ____/____/____

**(3) Tetanus/Diphtheria/Pertussis:** Primary Series Completed ____/____/____ Current TDAP Booster ____/____/____

**(4) Polio:** Primary Series Completed ____/____/____

**(5) Tuberculosis Screening** (Health Care Provider to Determine): THIS IS REQUIRED FOR ALL INTERNATIONAL STUDENTS

1. Does the student have signs or symptoms of active tuberculosis disease? Yes ___ No ___ If no, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health profession? Yes ___ No ___ If no, stop. If yes, enter tuberculin skin test Mantoux only below. A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test: Date given: ____/____/____ Date Read: ____/____/____ Interpretation (based on mm duration as well as risk factors):
4. Chest x-ray (if above is positive): Results: Normal ____ Abnormal ____ Date of chest x-ray ____/____/____

## RECOMMENDED IMMUNIZATIONS

**(6) Hepatitis B: Dose #1** ____/____/____ **Dose #2** ____/____/____ **Dose #3** ____/____/____

**(7) Varicella:** (A history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart.)
History of the disease: Yes ___ No ___ Varicella antibody ____/____/____ Reactive ___ Non-reactive ___
Immunization: **#1** ____/____/____ **Dose #2** ____/____/____

**(8) Quadrivalent Human Papilloma Vaccine (HPV) #1** ____/____/____ **Dose #2** ____/____/____ **Dose #3** ____/____/____

**(9) Hepatitis A Dose #1** ____/____/____ **Dose #2** ____/____/____
**(10) COVID vaccine #1** ____/____/____ **Dose #2** ____/____/____

Is the student now under treatment or medical or emotional condition: Yes ___ No ___
Recommendations regarding the care for this student: _____

_____

***Physician's/Health Care Provider's Signature***
***This includes school nurse, registered nurse, doctor, ARNP, or PA-C***

_____

**PLEASE PRINT:** Health Care Provider's Name Provider's Street Address City, State, Zip Phone Number

**Mail completed original form to:** Morningside University Student Health, 1501 Morningside Avenue, Sioux City, IA 51106

The Morningside University experience cultivates a passion for **lifelong learning** and a dedication to **ethical leadership** and **civic responsibility**.

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## STUDENT HEALTH HISTORY

Today's Date

Name _____ Gender_____ Date of Birth _____

Email _____

Address _____ Student's Phone _____

**Individual Providing Health History - and relationship to student (if not student):** _____

Emergency Contact #1 _____ Phone _____

Emergency Contact #2 _____ Phone _____

Current Health Care Provider Name _____ Phone _____

Are you a veteran? Yes ___ No ___

Do you have an ongoing health concern? (Asthma, Diabetes, etc.) Yes ___ No ___

If yes, please describe _____

Do you have any allergies? (include environmental and medical) Yes ___ No ___

If yes, please list _____

Has the allergy required medical emergency medial treatment? Yes ___ No ___

If yes, please explain _____

Have you had any hospitalizations, significant injuries or surgery? Yes ___ No ___

If yes, please describe _____

Are there any current medical concerns/injuries? Yes ___ No ___

- ☐ Head_____ ☐ Eyes_____ ☐ Nose _____
- ☐ Ears_____ ☐ Throat _____ ☐ Neck _____
- ☐ Chest_____ ☐ Respiratory_____
- ☐ Cardiovascular _____ ☐ Gastrointestinal_____
- ☐ Genitourinary _____ ☐ Neurological_____
- ☐ Musculoskeletal (include any past fractures, etc. _____
- ☐ Emotional/Behavioral_____

Do you take any medications/supplements regularly? Yes ___ No ___

If yes, please list medications taking _____

If yes, please list supplements taking _____

### Family History

| AGE | STATE OF HEALTH | OCCUPATION | AGE, CAUSE OF DEATH | **Condition(s) any relative has/has had:** |
|---|---|---|---|---|
| Mother | | | | Tuberculosis _____ |
| Father | | | | Diabetes_____ |
| Brother | | | | Kidney Disease_____ |
| Brother | | | | Heart Disease _____ |
| | | | | Asthma, Hay Fever_____ |
| Sister | | | | Cancer _____ |
| Sister | | | | High Blood Pressure _____ |
| | | | | Epilepsy, Convulsions _____ |

### Social - Tell Us:

Sleep: Average hours per night _____

Exercise: Average minutes per day_____

Alcohol use: if yes, what and how often _____

Nutrition: # of servings of fruits/vegetables per day _____

Tobacco use: if yes, what and how often _____

Recreational drug use: if yes, what and how often _____

Do you have an Advanced Medical Directive? Yes ___ No ___

**If yes**, please list contact name/relationship/phone _____

_____

**If no**, what are your wishes if unable or unwilling to speak for yourself medically? _____

_____

Please list any additional concerns or information not covered. (Use separate page as needed) _____

_____

_____