MUSKINGUM UNIVERSITY STUDENT HEALTH CENTER
260 Stadium Drive
NEW CONCORD, OHIO 43762
(740) 826-8150 FAX: (740) 826-8151

Please complete the following information and submit to the Student Health Center before you arrive on campus. Our facility follows the American College Health Association guidelines regarding health history form submission and immunization requirements. **Note:** All health services and documents will be considered confidential and are protected by the Student Health Center information disclosure policy.

STUDENT HEALTH HISTORY

Name _____
(First) (Middle) (Last)
Date of Birth_____
Home Address_____
(Street) (City) (State) (Zip Code)
Home Telephone (___) ___-_____ Cell Telephone (___) ___-_____
Person(s) to be contacted in an emergency:
_____(___) ___-_____(___) ___-_____
(Name) (Relationship to you) (Home or cell phone) (Business phone)
Primary Health Care Provider_____(___) ___-___(___) ___-_____
(Current Physician) (Name) (Telephone) (Fax)
Health Insurance Information (family policy_____(___) ___-_____
(Company) (Telephone)Card and/or Group Number
Policy Holder Name_____****Attach Insurance Card****
Policy Holder DOB _____

MEDICAL HISTORY RECORD

ALLERGIES
Please list all **medications** to which you are allergic or sensitive _____
_____
Please list all **foods, environmental substances, pets or insect stings** to which you are allergic or sensitive _____
_____

CURRENT MEDICATIONS
Please list all medications (with dosage) taken on a daily basis _____
_____

PERSONAL HEALTH HISTORY
Please indicate (x) if you currently have or have been treated in the past for any of the following conditions or health issues (additional space provided below for further explanation):

___Anemia/Blood Disorder	___Alcoholism or Chemical Dependence	___ADHD	____Anxiety/Depression
___Appendicitis	___Asthma	___Chicken pox	____Cancer
___Chronic Disease	___Colitis/IBS	___Eating disorder	____Eye Disease
___Ear problems	___Headaches/migraine	___Heart Disorder	____Concussion
___Hepatitis	____High blood pressure	___HIV/AIDS	____Diabetes
___Herpes Simplex	____Kidney Disease	__Liver Disease	____Bone/Joint Disorder
___Meningitis	___Major trauma/multiple injuries	___Mononucleosis	
___Pneumonia	____Psychological/psychiatric issues	___Rheumatic Fever	
___Sinusitis	____Skin Disorder	___Tonsillitis	
___Tuberculosis	____Other medical problems	___Hospitalization	

Please provide additional information about your responses, if appropriate: _____
_____

IMMUNIZATION RECORD (please provide specific dates)

IMMUNIZATION	**REQUIRED**	DATE(S)
Tetanus-Diphtheria (Td) or Tdap (Tetanus/Diphtheria/Pertussis) (Specify which given)	Booster within past 10 years	_____
Polio	Primary childhood series	_____
MMR (Measles, Mumps, Rubella)	2 doses after 1 yr. of age	1)_____ 2)_____
TB test (Mantoux PPD) *	Result	_____

*Negative result required within past year (if positive, provide copy of chest x-ray report)

BCG vaccine (TB) **International Students ONLY** _____

Hepatitis B (Series of 3)	Recommended	1)_____ 2)_____ 3)_____
Meningococcal (Serogroup B)	Recommended	1)_____ 2)_____
Varicella (Chicken Pox)	Recommended	1)_____
Meningococcal (A,C,Y,W)	Recommended	1)_____
Influenza (Date of Last Dose)	Recommended	1)_____
Human Papillomavirus Vaccine	Recommended	1)_____ 2)_____ 3)_____
Hepatitis A (2 or 3 Doses)	Recommended	1)_____ 2)_____ 3)_____

Covid-19 Vaccine - **Highly Recommended- Attach Documentation**

Name of Vaccine: _____Date: 1)_____2)_____

Booster Date:_____

AUTHORIZATION FOR MEDICAL TREATMENT- I certify that the provided information is true and correct to the best of my knowledge. Authorization is granted, by the undersigned, to the Student Health Center staff for provision of necessary medical evaluation and treatment.

Student Signature_____ Date _____

Parent Signature (if student under 18 yrs.)_____ Date _____