

# STEPHENS COLLEGE

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Entrance

## Health Statement

\_\_\_\_\_  
Date of Birth

FR SO JR SR  
Status on Entry (Circle one)

Sex: M( ) F( )

Resident Student ( )  
Non-Resident Student ( )

Return Completed Form to:  
Director of Health Services  
Stephens College  
1200 E. Broadway,  
Campus Box 2045  
Columbia, Missouri 65215

\_\_\_\_\_  
Cell Phone Number

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle

\_\_\_\_\_  
Home Address (Number and Street)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Name and Relationship of Next of Kin to be Notified in an Emergency

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

## INSURANCE INFORMATION

It is required that all Stephens College students carry health insurance. Information about individual health insurance coverage can be obtained from the Residence Life office. Please provide your health care coverage information below: (and/or provide a copy of your insurance card)

Name of Insurance company \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Group Number \_\_\_\_\_ ID number \_\_\_\_\_

## IMMUNIZATION REQUIREMENTS

Missouri State Law requires all students living in dorms to be vaccinated against Meningococcal Meningitis. Stephens College requires two MMR vaccines and recommends the Hepatitis B series, Varicella (if student has not had Chicken Pox) and an up to date Tetanus. Please provide documentation from your high school, doctor or other health care provider of compliance with these requirements.

## CONSENT FOR TREATMENT IN HEALTH SERVICES (Required for students under 18 years of age)

In the event of a medical need for the above named student while she/he is a student at Stephens College, we hereby authorize the performance upon said student any medical procedures as may be prescribed by a licensed health care provider.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Family History						
	Name	Age	State of Health	Marital Status	Cause of Death	Age at Death
Father						
Mother						
Siblings						

Have any of your relatives had any of the following?			
	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Cancer			
Liver Tumors			
Heart Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			
High Blood Pressure			
Alcohol Abuse			

PERSONAL HISTORY (Please answer all questions, comment on all positive answers in space below or on additional sheet)											
Have You Had:	Yes	No	Have You Had:	Yes	No	Have You Had:	Yes	No	Have You Had:	Yes	No
Measles			Recurrent Colds			Insomnia			FEMALES ONLY		
German Measles			Hay Fever			Frequent Anxiety			Irregular Periods		
Mumps			Asthma			Recurrent Headache			Severe Cramps		
Chicken Pox			Tuberculosis			Head Injury/Unconsciousness			Excessive Flow		
Malaria			Chronic Cough			Dizziness/Fainting			Abnormal Pap Smear		
Sexually Transmitted Disease			Shortness of Breath			Weakness/Paralysis			Pregnancy		
Gum or Tooth Trouble			Mononucleosis			Depression			SURGERY		
Liver Disease			Pneumonia			Eye Trouble			Appendectomy		
Stomach, Intestinal Problems			Anemia			Diabetes			Tonsillectomy		
Gall Bladder Problems			Pain/Pressure in Chest			Albumin/Sugar in Urine			Other		
Recurrent Diarrhea			Heart Palpitations			Blood in Urine			ALLERGIES		
Recent weight change			High/Low Blood Pressure			Tumor/Cancer/Cyst			Penicillin		
Sinusitis			Rheumatic Fever/Heart Murmur			Bone Fracture			Sulfonamides		
Ear/Nose/Throat Problems			Seizures						Other		

Additional Questions: (use space below, if needed)	YES	NO
Has your physical activity been restricted during the past five years? (Give reasons and durations)		
Have you received treatment or counseling for a nervous condition, personality disorder, or emotional problem? (Give details)		
Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
Do you have a physical disability? (List)		
Do you take any medication at present? (List)		
Do you smoke cigarettes? # of packs per day?		
Do you drink alcohol?		
Do you or have you had a drinking problem?		
Do you or have you had a drug problem?		
Do you or have you had an eating disorder/problem?		
Have you ever used tranquilizers or other psychotropic drugs?		
Are you under treatment for any medical or emotional condition? (If yes, explain)		

ADDITIONAL REMARKS:

IMMUNIZATIONS	DATE Received ( MONTH/DAY/YEAR)
MMR #1	
MMR #2	
Hepatitis B #1	
Hepatitis B #2	
Hepatitis B #3	
Meningitis	
Tetanus/Diphtheria	
Varicella	
HPV #1	
HPV #2	
HPV #3	

TUBERCULOSIS Screening: (Check any that apply or give test results)

- \_\_\_\_\_ From or have lived two months or more outside the US
- \_\_\_\_\_ Chronic medical condition that impairs immune system
- \_\_\_\_\_ Health care worker
- \_\_\_\_\_ Close contact with persons known or suspected to have TB
- \_\_\_\_\_ Employee or volunteer of high-risk congregate settings such as correctional facilities, nursing homes, mental institutions, other long-term residential facilities
- \_\_\_\_\_ Current or past injectable drug use
- \_\_\_\_\_ None of the above

If any of the above apply, TB skin testing (PPD) is required:

Test Date: \_\_\_\_\_ Result: \_\_\_\_\_