Office of Health Services
513 Stanton Street
Lebanon, IL 62254
Phone: (618) 537-6503
Fax: (618) 551-2175

Complete?: Y ☐ N ☐	Reviewer:
Missing Items:	Contact Attempts:

McKendree University

Confidential Medical History and Immunization Record

Students are *required* to have the following information completed before they can reside in student housing or register for classes. Failure to comply with the Illinois State Mandate will result in a $50.00 fee and a HOLD being placed on registration by the Office of Health Services.

To be completed by the student:

Biographic Information

Student ID: _____ First Semester of Attendance: _____

Name: _____ Date of Birth: _____
(last) (first) (middle)

Home Address: _____
(number and street) (city) (state) (zip)

Mailing Address: _____
(if different from above)

Phone Number: _____ Non-McKendree Email: _____

Sport/Team/Organization you will be participating in at McKendree_____

Emergency Contact

Name: _____ Relationship: _____

Home Address: _____
(number and street) (city) (state) (zip)

Telephone: Business: _____ Residence: _____ Other: _____

Insurance

Name of company: _____ Policy Number: _____

City: _____ State: _____ Country: _____ Postal Code: _____

Social Security Number of Student (If applicable): _____

(Note: It is *mandatory* for all international students to obtain health insurance prior to final course registration)

Privacy Rights Waiver

Information in this medical report may be used to plan health care, adjudicate claims, provide classification for physical activities, and control communicable disease. In order to provide health care, the above named persons (or a substitute) may be given information judged necessary by an authority representing McKendree University.

Signature of Student: _____Date:_____

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To be completed by the student:

Part I. Confidential Medical History

Have you had or are you subject to any of the following? Please give dates.

____Appendicitis	**____Pelvic Disorders**	**____Kidney Troubles**	**____Asthma**
____Chickenpox	**____Diabetes**	**____Hernia**	**____Poliomyelitis**
____Tonsillitis	**____Hay Fever**	**____Scarlet Fever**	**____Pleurisy**
____Typhoid Fever	**____Pneumonia**	**____Skin Disease**	**____Malaria**
____Measles	**____Epilepsy**	**____Rheumatic Fever**	**____Abdominal Pain**
____Mental Illness	**____Heart Trouble**	**____Tuberculosis**	**____Emotional Problem**
____Shortness of Breath	**____Moody**	**____Headaches**	**____Defective Vision**
____High Blood Pressure	**____Cough**	**____Whooping Cough**	**____Mononucleosis**
____Joint Pains	**____German Measles**	**____Sinus Infection**	**____Jaundice**
____Diphtheria	**____Mumps**	**____Defective Hearing**	
____Family History of High Blood Pressure			

Do you know of any physical disability which may make it unwise for you to engage in Physical Education activities?
Explain:

_____

_____

Do you have any food and/or medication allergies? _____

_____

Are you on any maintenance medication and for what condition? _____

_____

Injuries: _____ **Date:** _____

_____ **Date:** _____

Operations: _____ **Date:** _____

_____ **Date:** _____

Please add any further notes about your health which you think might be of value to the Office of Health Services:

_____

_____

_____

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Part II. Immunization Record

A copy of your immunizations (available at your high school, doctor's office, or previously attended university) may be faxed to Health Services at (618) 537-6955 or attached to this form in place of completing this section.

As of July 1989, all students born after January 1, 1957 registering for the first time at public or private colleges in Illinois must present evidence of immunity against the vaccine-preventable diseases.
If no proof of immunization, certification of medical exemption, or statement of religious objection is presented, the student will not be permitted to register for courses
(Public Act 85-1315). *** REQUIRED**

A. MMR*

(Measles, Mumps, Rubella) Two doses required.
Dose #1 given at ages 12–15 months or later #1_____

Dose #2given at least 28 days after first dose #2_____

Evidence of immunity by lab titer: Date: _____ Results: _____

B. Tetanus-Diphtheria-Pertussis*

Primary series with DtaP, DTP, DT or Td, and booster with Td or Tdap in the last ten years.

1. Primary series of four doses with DtaP, DTP, Dt or Td:
   #1_____#2_____#3_____#4_____

Date of most recent booster dose: _____Within the last 10 years *

C. Meningococcal Quadrivalent / Meningitis* #1_____ #2_____

D. Hepatitis A (Highly advisable for International travel)

1. Immunization (Hepatitis A): #1_____ #2_____

2. Immunization (Combined Hepatitis A and B vaccine):
   #1_____ #2_____#3_____

E. Hepatitis B (Highly advisable)

Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive Hepatitis B surface antibody.

#1_____#2_____#3_____

F. Varicella (highly advisable)

Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or 2 doses of vaccine.
1. History of disease: ____Yes _____No
2. Varicella antibody: Result: _____Reactive _____Non-reactive
3. Immunization: Dose #1 _____Dose #2 _____

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To be completed by the physician:

1. Laboratory Work (Required for International students *only*):

Blood Analysis: **Date: _____ Hemoglobin: _____ Hematocrit: _____**

Urinalysis: **Date: _____ Specific Gravity: _____ Albumin: _____**

Sugar: _____ Blood: _____ Micro: _____

Tuberculin Test: **Date: _____ Results: _____**

If positive, chest X-ray required: **Date: _____ Results: _____**

Recommended Immunizations

The following are optional immunizations, but are strongly recommended for all students:

1. Flu Vaccine

Vaccine Date: _____

Vaccine Date: _____

2. Quanti-FERON TB-Gold (within past 12 months)

Lab test date: _____
Results: _____
(Attach copy of laboratory report)

Has patient had a previous positive skin test? ☐ **Yes** ☐ **No**

Has patient received BCG? ☐ **Yes** ☐ **No**

Tuberculosis Skin Test

Test Date: _____ Skin Test Results: _____mm
(month / day / year)

Signature of Physician: _____ Date: _____

Name of Physician (print or type): _____

Mailing Address: _____
(number and street) (city) (state) (zip)