MOUNT MARTY
COLLEGE

Comprehensive Student Health Form

All students planning to attend Mount Marty College are required to submit this completed form PRIOR to the first day of classes.

In order to provide you the best possible health care while you are a student at Mount Marty College, we require you to complete this form prior to the first day of classes. The Health History is essential for appropriate treatment of acute conditions, to ensure continuity of care for chronic conditions and to comply with statutes concerning student immunizations. All information obtained is regarded as confidential and will be shared with other college personnel only on a need-to-know basis. PLEASE MAKE A COPY OF THE COMPLETED FORM FOR YOUR FUTURE USE.

Answer all questions. Complete the Health History, Immunizations, Emergency Medical Information, and Mental Health History forms. **Please return or mail completed form directly to the Office of Student Affairs, 1105 West 8th St., Yankton SD 57078.**

Student Name	Date of Birth
Email Address	Cell Phone Number
Off Campus Address	City, State, Zip Code
Student Signature	Date
Guardian Signature (if student is under 18)	Date

Revised April 2012

CONFIDENTIAL — Immunizations

TO BE COMPLETED BY A HEALTH PROFESSIONAL

Personal History (please complete in ink)

Student Name____ DOB _____ / _____/ _____
Last First Middle

A. REQUIRED OF ALL STUDENTS

Two doses of MMR (measles, mumps, rubella)

1. MMR First Dose (immunized after age 12 months) Date _____/_____/_____
2. MMR Second Dose (immunized at least 28 days after first dose) Date _____/_____/_____
3. _____ Check here if you were born before January 1, 1957 for age exemption for measles, mumps, rubella.
4. Tuberculin Skin (mantoux required, tine not accepted) Tuberculin skin test must be administered within one year before entering college. International students: Tuberculin skin test must be administered within 4 weeks prior to attending Mount Marty.
   a. Does the student have signs or symptoms of **active tuberculosis** disease? Yes ☐ No ☐ If No, proceed to section b. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
   b. 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*.
   c. Tuberculin Skin Test Date Given _____/_____/_____ Date Read _____/_____/_____
   Interpretation (based on mm of induration as well as risk factors.): ______________________
   Induration ______ mm Positive _____ Negative ____
   d. Chest x-ray (if above is positive) Results: Normal ____ Abnormal ____ Date of chest x-ray: ____/_____/_____
5. Tetanus-Diphtheria
   Completed primary series Date _____/_____/_____
   Tetanus Diphtheria booster within last 10 years or Date _____/_____/_____
   Tdap (Tetanus, Diphtheria, Acellular Pertussis) Date _____/_____/_____
6. Meningococcal - The American College Health Association recommends that students consider a one-time dose meningitis vaccine to reduce the risk for potentially fatal bacterial meningitis. (For questions, read information at Centers for Disease Control website: www.cdc.gov/nip/publications/VIS/vis-mening.pdf AND consult 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) Menactra (MCV4) Vaccine** Date _____/_____/_____
OR
Menomune (MPSV4) Vaccine Date _____/_____/_____

B. RECOMMENDED BUT NOT REQUIRED FOR ENROLLMENT

1. Polio
   Completed primary series _____ oral _____IPV Date _____/_____/_____
   Last Polio booster Date _____/_____/_____
2. Hepatitis B (required for students in health professional majors)
   Completed Series Dose 1 Date _____/_____/_____
   Dose 2 Date _____/_____/_____
   Dose 3 Date _____/_____/_____
3. Varicella (Either a history of chicken pox, a positive Varicella antibody or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)
   History of Disease: Yes ☐ No ☐ Varicella antibody Date _____/_____/_____ Reactive ___ Non-reactive ___
   Immunization: Dose #1 Date _____/_____/_____
   Dose #2 *(Dose #2 given at least one month after first dose, if age 13 years or older.)* Date _____/_____/_____

C. TO THE HEALTH PROFESSIONAL

Please review the requirements, administer the needed immunizations and sign below to validate the recorded data.

Signed ____ Date _____/_____/_____
(physician, nurse, school health authority)

Printed Name ____________________________ Address ________________________________

D. MEDICAL EXEMPTION

The student named above does not have one or more of the required immunizations because he/she has a medical problem that precludes the ____________________ vaccine or has shown laboratory evidence of immunity against_______________.

Physician Signature____ Date _____/_____/_____

CONFIDENTIAL — Health History

You must complete the CSH Form prior to your first day of classes and before receiving health care at the student health office.

1. Student Name ___________________________________ DOB _____/ _____/ _____ Sex ______
   Last First Middle

2. Year in College: 1 2 3 4 Marital Status: S M W Div/Sep

3. Family Physician _______________________ Address ____

4. In Case of Emergency Contact:

   Name ____ Relationship __________________________

   Address _____________________________________ (City, State, Zip) _____________________________

   Phone (work) ___________________ (home) ___________________ (cell) ________________________

5.

Family History	Age(s)	Living	Deceased	Cause of Death	Year of Death
Father:					
Mother: (include maiden name)					
Brother(s):					
Sister(s):					

6. Have any of your family or near relatives had any of the following:

	Yes	**No**	**Relationship**
Alcoholism	_______	_______	______________________
Arthritis	_______	_______	______________________
Asthma	_______	_______	______________________
Cancer	_______	_______	______________________
Chemical Dependency	_______	_______	______________________
Diabetes	_______	_______	______________________
Epilepsy	_______	_______	______________________
Hay Fever	_______	_______	______________________
Heart Disease	_______	_______	______________________
Kidney Disease	_______	_______	______________________
Psychiatric Disorder	_______	_______	______________________
Stomach or Bowel Disease	_______	_______	______________________
Tuberculosis	_______	_______	______________________

Personal History (to be completed by student) **Do you have a history of:** (explain yes answers in space below)

	Yes	No
1. Skin disease	_____	_____
2. Frequent, severe headaches	_____	_____
3. Severe head injury	_____	_____
4. Ear, nose, throat problems	_____	_____
5. Eye or vision problems	_____	_____
6. Hearing difficulties and/or loss	_____	_____
7. Asthma	_____	_____
8. Thyroid disorder	_____	_____
9. Hay fever or other allergies	_____	_____
10. Bronchitis or pneumonia	_____	_____
11. Tuberculosis	_____	_____
12. Chronic cough, colds	_____	_____
13. Chest pain, pressure	_____	_____
14. Heart murmur	_____	_____
15. High or low blood pressure	_____	_____
16. Heart palpitations	_____	_____
17. Rheumatic fever	_____	_____
18. Stomach or intestinal problems, ulcers	_____	_____
19. Gall bladder disease	_____	_____
20. Hernias	_____	_____
21. Hemorrhoids	_____	_____
22. Recurrent diarrhea	_____	_____
23. Bladder/kidney infections	_____	_____
24. Sexually transmitted disease	_____	_____
25. Menstrual problems	_____	_____

	Yes	No
26. Bone or joint disease, arthritis	_____	_____
27. Back pain	_____	_____
28. Loss of extremity or part	_____	_____
29. Anxiety/panic attacks	_____	_____
30. Depression	_____	_____
31. Psychiatric disorder	_____	_____
32. Insomnia, difficulty sleeping	_____	_____
33. Dizziness, fainting	_____	_____
34. Eating disorder	_____	_____
35. Recent weight loss or gain	_____	_____
36. Diabetes	_____	_____
37. Chemical dependency	_____	_____
38. Alcoholism	_____	_____
39. Epilepsy	_____	_____
40. Chicken pox	_____	_____
41. Mononucleosis	_____	_____
42. Hepatitis (specify type)	_____	_____
43. Pregnancies	_____	_____
44. Tobacco use	_____	_____
45. Alcohol use	_____	_____
46. Hospitalizations (specify)	_____	_____
47. Surgeries (specify)	_____	_____
48. Broken bones, sprains, strains	_____	_____
49. Other ________________________		

Explain "yes" answers:

____

____

7. Height ____________ Weight ____________

8. Allergies: _____ I do not have allergies
_____ I am allergic to the following medications ______________________
_____ I am allergic to the following foods ______________________
_____ I am allergic to ______________________

9. Are you on a special diet? __________ Reason and type of diet ______________________

10. Do you have regular dental check-ups? Yes _____ No _____ If yes, how often? ______________

11. Are you presently taking any prescription or over the counter medications? (specify) ____________

____

12. Are you receiving treatment for any emotional or physical health problems at the present? (please explain)

____

13. I certify the information on this health questionnaire is correct to the best of my knowledge.

______________________ Student's Signature ________ Date ______________________ Parent/Guardian Signature ________ Date

Disability Accommodations

Accommodations are provided in accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 for eligible students upon request. Eligible students must provide documentation that appropriately substantiates the need for requested accommodations. If you need accommodations, please contact the Disabilities Services Office at 668-1600. Forms and information on the accomodations web process can also be found on the Disabilities Services webpage under Student Life.

Mental Health History Form

All information disclosed on this for will be kept confidential and will be shared with appropriate college personnel on a need-to-know basis only.

1. Are you under the care of a mental health professional currently? Yes ____ No _____

2. Have you been hospitalized for a psychiatric disorder? Yes ____ No ____

   (Specify dates) ____

Please check below if you have experienced any of the following during high school or prior to enrollment at Mount Marty?

	Yes	No	Age	Date of treatment
1. Depression	____	____	_____	_______________
2. An anxiety disorder	____	____	_____	_______________
3. An eating disorder	____	____	_____	_______________
4. Bipolar disease	____	____	_____	_______________
5. Obsessive-compulsive disorder	____	____	_____	_______________
6. An anger management issue	____	____	_____	_______________
7. PTSD	____	____	_____	_______________
8. ADD/ADHD	____	____	_____	_______________
9. A suicide attempt	____	____	_____	_______________
10. Self-injurious behavior	____	____	_____	_______________
11. Suicidal thoughts	____	____	_____	_______________
12. A sleep disorder	____	____	_____	_______________
13. Panic disorder	____	____	_____	_______________
14. An anti-social or conduct disorder	____	____	_____	_______________
15. Alcohol or substance abuse or dependence	____	____	_____	_______________

16. Other (please specify) ____________________________________
17. Are you now taking or have you ever taken medication for any of the above? Yes ____ No ____
18. Do you intend to begin or continue medication or counseling during college? Yes ____ No ____

______________________________ Student's Signature

______________________________ Date

Emergency Medical Information

Name____ DOB _____ / _____/ _____

Last First Middle

In case of emergency, please contact:

Name_________________________________ Relationship_______________________

Day Phone (____)______________________________ Evening Phone (____)________________

Cell Phone (____)______________________________

INSURANCE (Please be sure to bring your insurance card with you AND attach a front and back copy for our records.)

Full time students are billed the yearly cost of the insurance in the fall and enrolled in the program unless a signed waiver card is returned to the Business Office.

Subscriber Name____

Carrier Company____

Group #______________________________________ Policy #__________________________

[Note: Full disclosure is important for proper care in case of emergency.
All information is kept confidential by the Office of Student Affairs.]

MEDICATIONS YOU TAKE REGULARLY

1.____ For:__________________________

2.____ For:__________________________

3.____ For:__________________________

MEDICAL CONDITIONS: (diabetes, heart, etc.)

1.____

2.____

3.____

ALLERGIES:

1. ____

2. ____

3. ____

PARENT/GUARDIAN MEDICAL RELEASE (Must be completed for students less than 18 years of age.) I give permission for diagnostic, therapeutic and/or operative procedures should an emergency arise. In such an instance, Mount Marty College, through its physician or other medical authority, may act with my approval in treating my son/daughter/ward.

____ ________________________________

Signature Date

____

Relationship