Elmhurst College

Please submit the form via mail or fax no later than June 1 for Fall Semester and December 1 for Spring Semester

STUDENT HEALTH SERVICE
190 Prospect Avenue, Elmhurst, Illinois 60126-3296
Phone: (630) 617-3565 Fax: (630) 617-3255
Email: studenthealth@elmhurst.edu

Last Name	First Name	M.I.	Date of Birth (mm/dd/yy)	Student ID (7 digits)
Home Address	City/State/Zip	Country	Gender	Student Cell Phone
Semester and year of first enrollment: ☐ Fall (year) _____ ☐ Spring (year) _____ ☐ Summer (year) _____			Email	

IMMUNIZATION RECORD:

A physical exam is not required. It is an Illinois State Law for all students attending a four-year college and born after 1956 to obtain certain immunizations. You may have your primary care provider, former high-school, or previous college fax your records to the Student Health Service. If you are unable to obtain your immunization dates, you will need to be revaccinated or have an immunity profile (blood test) done to confirm your immunity. Vaccines, TB skin tests, and immunity profiles are available in the Student Health Services for a fee. **All forms must be submitted no later than June 1 for Fall and December 1 for Spring. Students with incomplete immunization records will be put on a "medical hold" and will be unable to register for classes in their second semester.**

REQUIRED IMMUNIZATIONS *(Dates Required)*

MMR (measles, mumps, rubella)	2 doses of MMR vaccine administered on or after 12 months of age ***OR*** positive serum titers to all three diseases (attach lab report)	1. _____ mm/dd/yy	2. _____ mm/dd/yy
MENINGOCCAL CONJUGATE VACCINE	Menactra or Menveo is required for all students 21 years of age and younger. NOTE: A 2nd vaccine must be given if the 1st vaccine was given before age 16.	1. _____ mm/dd/yy	2. _____ mm/dd/yy
Tetanus-Diphtheria-Pertussis (DPT, DTP, DT, DTap, Td, Tdap)	Any combination of three or more doses of Tetanus-Diphtheria-Pertussis. One dose must be Tdap. The last dose must be within ten years of the first day of the first semester.		

1. _____ mm/dd/yy	☐ Td ☐ Tdap ☐ DTP/DTap	2. _____ mm/dd/yy	☐ Td ☐ Tdap ☐ DTP/DTap	3. _____ mm/dd/yy	☐ Td ☐ Tdap ☐ DTP/DTap

RECOMMENDED IMMUNIZATIONS *(Complete if received)*

HEPATITIS B (Series of 3)	1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy
VARICELLA (Chicken Pox)	1. _____ mm/dd/yy	2. _____ mm/dd/yy	☐ Had Varicella (Chickenpox)

INTERNATIONAL STUDENTS ONLY: *Call Student Health Services at (630) 617-3565 for a Tuberculosis Screening when you arrive on campus.*

Tuberculosis Skin Test/PPD	1. _____ mm/dd/yy	Results: ☐ Negative ☐ Positive mm induration: _____

REQUIRED HEALTH CARE PROVIDER INFORMATION

Provider name (print or stamp)	Date
Address	Phone

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Last Name	First Name	M.I.	Date of Birth (mm/dd/yy)	Student ID (7 digits)
Home Address	City/State/Zip	Country	Gender	Student Cell Phone

PERSONAL HEALTH HISTORY: *Please check all conditions/diseases you have had. If none apply, check this box* ☐

General
- ☐ Anemia
- ☐ Autism Spectrum
- ☐ Cerebral Palsy
- ☐ Fatigue
- ☐ Learning Disorder
- ☐ Sleep Issues
- ☐ Weight Gain/Loss (recent)

Skin
- ☐ Acne
- ☐ Eczema
- ☐ Skin cancer
- ☐ Psoriasis

Head/Ears/Eyes/Nose/Throat
- ☐ Chronic Ear Infections
- ☐ Hearing Impairment
- ☐ Visual Impairment

Cardiovascular/Vessel
- ☐ Blood Clotting Disorder
- ☐ Congenital Heart Defect
- ☐ Heart Murmur
- ☐ High Blood Pressure

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia

Gastrointestinal
- ☐ Celiac Disease
- ☐ Crohn's Disease
- ☐ Diverticulosis
- ☐ Dyspepsia (Heartburn)
- ☐ Gallbladder Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis

Genitourinary/Gyne
- ☐ Hernia
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Menstrual Conditions
- ☐ Urinary tract Infections

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Scoliosis
- ☐ Skeletal Disorder

Neurological
- ☐ Congenital /Spinal Cord Injury
- ☐ Head Injury/Concussion
- ☐ Headache, reccurent
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder

Endocrine
- ☐ Diabetes
- ☐ (PCOS) Polycystic Ovarian Syndrome
- ☐ Thyroid Disorder

Emotional Health
- ☐ Alcohol/Substance Abuse
- ☐ Anxiety/Panic Attacks
- ☐ Attention Deficit (ADD/ADHD)
- ☐ Depression
- ☐ Eating Disorder
- ☐ Mental Health Hospitalization
- ☐ PTSD
- ☐ Suicidal Thoughts

Infectious Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Meningitis
- ☐ Tuberculosis

Other:
- ☐ _____
- ☐ _____

Surgeries, conditions or hospitalizations not listed above: ☐ **None**

Routine medications/vitamins/supplements (please list drug, dose and reason): ☐ **None**

Allergies (please list allergies to medications, foods, environmental or insects): ☐ **None**

FAMILY HISTORY: *Has any immediate family member had any of the following?*

- ☐ Alcohol/Substance Abuse
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Mental Health Treatment
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Sudden Death before age 50
- ☐ Adopted, History Unknown
- ☐ Other _____

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

Name	Relationship	Phone
Name	Relationship	Phone

Parent Consent for Treatment: All students under 18 years of age enrolled at Elmhurst College must have parental permission before they may receive medical care at Student Health Service. We ask that you sign this statement. I hereby give permission for the medical staff of Elmhurst College Student Health Services to perform diagnostic and therapeutic treatment as they deem necessary.

Signature of parent/guardian of student under 18	Date