Medical and Immunization Record

Name _____ ☐ Female ☐ Male

Date of birth _____/_____/_____Country of birth _____

Date of enrollment (month/year) _____ ☐ Undergraduate Year (circle one) 1 2 3 4

☐ Seminary ☐ Graduate ☐ Part-time (< 6 credit hours) ☐ Full-time (> 6 credit hours) ☐ Online program

Note: All students must complete and return this form to Health Services.

Athletic and nursing physicals are not a substitution for this form.

Immunizations

Please attach a copy of an official print out from your electronic medical record, high school immunizations records, or a copy of an authorized immunization record as evidence of following vaccine dates. All dates must have month, day, and year.

ALL RECORDS MUST BE IN ENGLISH OR TRANSLATED TO ENGLISH

Required Immunizations	Vaccine Date	Vaccine Date	Alternate Proof of Immunity
MMR (measles, mumps, rubella): Two doses of MMR, separated by more than one month. First dose must be on or after first birthday. **Note:** Measles, mumps, and rubella vaccines may have been given separately as opposed to altogether in one MMR vaccine.	1 ____/____/____	2 ____/____/____	May also show proof of titer (blood test results for measles, mumps, and rubella), but must attach lab results.
Tetanus/Diphtheria/Pertussis: Any combination of two or more of Diphtheria, Tetanus, or Pertussis containing vaccines; the last dose must be within the last 10 years. 1st and 2nd doses most be at least 4 weeks apart and the 3rd dose at least 6 months after the 2nd dose. One dose must be a Tdap vaccine.	1 ____/____/____	2 ____/____/____	3 (Booster within last 10 years) ____/____/____
Meningitis Conjugate (Menactra, MenHibrix, or Menveo [MCV4] or Menomune [MPSV4]): Only for students who are under the age of 22 years. One dose is required if you received it on or after your 16th birthday; two doses if you received the first dose before your 16th birthday.	1 ____/____/____	2 ____/____/____	

☐ Check if exempt from any of the above vaccines. Attach a written and signed statement from a physician for medical exemptions. Attach a written and personally signed statement for religious exemptions Please list out which vaccines are exempt.

RECOMMENDED VACCINES: Please provide month, day, and year.

Hepatitis B: 1st_____/_____/_____2nd_____/_____/_____3rd_____/_____/_____ **HPV vaccine:** 1st_____/_____/_____ 2nd_____/_____/_____

Meningococcal B Vaccine (Trumenda or Bexseero): 1st_____/_____/_____2nd_____/_____/_____ 3rd_____/_____/_____

Polio–Primary Series: Date completed_____/_____/_____Last Booster:_____/_____/_____

Tuberculosis Screening

Required for **ALL international students** and students who have studied abroad to high-risk countries

Provide documentation of a PPD test (Mantoux skin test) within past year UNLESS you have had a positive PPD result* OR received BCG vaccine at some point in your lifetime.*

PPD Date and Time: _____ Read Date and Time: _____ Result in mm:_____

Signature of MD/APN/PA/RN: _____

* If you have had a positive PPD result (current or in the past) or history of BCG vaccine, attach a copy of the Interferon Gamma Release Assay (IGRA) results. If IGRA is positive, provide a copy of your chest x-ray results or completed tuberculosis treatment.

Medical History Record

All medical records and information are strictly confidential and will not be released without your consent. Although it is recommended that students have a complete physical before attending college classes, it is not required. If a physical is completed, the physician, nurse practitioner, or physician assistant can sign on the following page.

Personal History

Explain positive answers and make additional comments on the last page of this form.

Have you had?	No	Yes	Date	Have you had?	No	Yes	Date	Have you had?	No	Yes	Date
ADD/ADHD				Epilepsy/Seizures				Post-traumatic Stress Disorder			
Allergy/Allergic Reaction				Eye Problem				Polycystic Ovarian Syndrome			
Anemia				Fracture/Sprain				Sinus Infection, recurrent			
Arthritis				Gall Bladder Disease				Skin Disorder/Acne			
Asthma				Head Injury/Concussion				Stomach Disorder			
Autoimmune Disease				Headaches/Migraines				Strep Throat, recurrent			
Back Problem				Heart Condition/Murmur				Sexually Transmitted Infection			
Bipolar Disorder				High Blood Pressure				Sleep Disturbances			
Bronchitis, recurrent				HIV/AIDS				Surgery –			
Cancer				Kidney Disease				– Appendectomy			
Chicken Pox				Liver Disease				– Tonsillectomy			
Counseling				Malaria				– Other			
Depression/Anxiety				Menstrual Problems				Tachycardia (rapid heart beat)			
Diabetes Mellitus				Mononucleosis				Thyroid Disorder			
Dizzy Spells/Fainting				Paralysis				Tuberculosis			
Eating Disorder				Pneumonia				Urinary Tract Infection			

Hospitalizations: Provide reason and the date(s): ☐ None _____

_____

Has your physical activity been restricted during the past five years? ☐ Yes ☐ No Provide reasons and dates: _____

_____

Have you traveled or resided outside of the United States? ☐ Yes ☐ No Provide where and when: _____

Date of last physical examination by a physician: _____

Current Health

List allergies to medications, foods, pollen, molds, other ☐ None _____

_____

List medications taken regularly ☐ None _____

Do you smoke/vape? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

Do you carry an epi pen? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes

Contact lenses? ☐ No ☐ Yes

Hearing Aids? ☐ No ☐ Yes

Please list any accesibility needs:

Family History

		State of Health					
	Age	Good	Fair	Poor	Deceased	Age of Death	Cause of Death
Father							
Mother							
Brothers and sisters							
		State of Health					
	Age	Good	Fair	Poor	Deceased	Age of Death	Cause of Death
Spouse							
Children							

Have any of your blood relatives had:

Autoimmune Disease □ No □ Yes Relationship: _____
Alcoholism □ No □ Yes Relationship: _____
Arthritis □ No □ Yes Relationship: _____
Asthma □ No □ Yes Relationship: _____
Cancer □ No □ Yes Relationship: _____
Diabetes Mellitus □ No □ Yes Relationship: _____
Epilepsy/Seizures □ No □ Yes Relationship: _____
Heart Disease □ No □ Yes Relationship: _____
High Blood Pressure □ No □ Yes Relationship: _____
Kidney Disease □ No □ Yes Relationship: _____
Mental Illness □ No □ Yes Relationship: _____
Stroke □ No □ Yes Relationship: _____
Suicide □ No □ Yes Relationship: _____
Thyroid Disease □ No □ Yes Relationship: _____
Tuberculosis □ No □ Yes Relationship: _____

In case of a health emergency, who should we notify? Name: _____ Relationship _____

Cell phone: (_____) - _____ - _____ Home phone: (_____) - _____ - _____ Work phone: (_____) - _____ - _____

I hereby certify to the best of my knowledge that the preceding information is complete and correct. I authorize North Park University to release the immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and health safety emergencies.

Signature of Student_____ Date _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

If examined by a physician (not required for admission): I find the above student to be in good physical and emotional health and find no reason why he/she cannot participate in normal University activities. Please attach copy of physical if done.

Signature of Physician_____ Date_____

Please use this space if you need to add further comments to your personal medical history.

North Park University
Health Services
3317 West Foster Avenue,
Chicago, Illinois 60625
Phone: (773) 244-4897
Fax: (773) 634-4060

NORTH PARK UNIVERSITY
CHICAGO