

HEALTH CERTIFICATE FOR NEW STUDENTS

This health certificate must be filled out by a physician and returned to the Health Service office before permission to register will be granted. **Please attend to promptly!**

PARENTS AND/OR STUDENT: PLEASE COMPLETE SECTIONS I THROUGH V

I. Student's Name _____ Admission Date _____
SEMESTER/YEAR

Home Address _____

Date of Birth ____ / ____ / ____ Sex: Male Female Social Security # _____

Person to notify in case of emergency _____

Address _____

Phone Number: Home (____) _____ Work (____) _____

If the above number cannot be reached, notify _____

Phone Number: Home (____) _____ Work (____) _____

II. In case of treatment as an outpatient at the hospital or should inpatient hospitalization be required, the bill for care will be sent directly to the student, parent, or legal guardian unless the name and policy number of insurance cover age is provided. If your son/daughter is covered by such a policy, please fill in the following.

Head of Household _____ Social Security # _____

Employer _____ Phone # (____) _____

Insurance Company _____ Policy Number _____

Insurance Company Address _____ Phone # (____) _____

III. I hereby authorize MacMurray College to inspect or secure copies of case history records, lab reports, diagnosis, x-ray, and any other data covering this and/or previous deemed as effective and valid as the original.

Parent/Guardian Signature _____

Student Signature _____

IV. Any person who has reached the age of 18 years of age may, in the state of Illinois, sign his/her own consent for treatment at a hospital or other medical care facility. If the student has not reached the age of 18, the following must be signed by the student's parent/guardian for the student to receive treatment.

I, _____, hereby give permission for emergency medical treatment for _____ should it become necessary before he/she reached his/her 18th birthday.

V. Health History

1. Do you have any **allergies** to medicines? Yes No

If yes, please specify _____

2. Do you have any other allergies? Yes No

If yes, please specify _____

3. Have you ever had any major illness or injury in the past four years? Yes No

If yes, please specify _____

4. Are you now taking any type of medication or treatment from a doctor which will be continued during the school year? Yes No

If yes, please specify _____

5. Are you currently taking any nonprescription medication? Yes No

If yes, please specify _____

6. Do you wear glasses/contact lenses? Yes No

7. Have you ever received psychiatric therapy or counseling? Yes No

If yes, please specify _____

Counselor Name _____ Phone (_____) _____

Dates Received Counseling _____

8. Please check if you have had any of the following diseases or been diagnosed with any of these health problems.

Chickenpox

Epilepsy/Seizure Disorder

Mononucleosis

Diabetes

Strep Throat

Heart Disease Problem/Murmur

Pneumonia

High Blood Pressure

Asthma

Kidney/Urinary Tract Problem

Hepatitis A, B, or C

Bleeding/Blood Disorder

Eating Disorder

Tuberculosis

Hearing Loss

Digestive Tract Problem

TO THE EXAMINING PHYSICIAN

Please fill out **Sections VI** through **VII** carefully. This information is necessary for the Health Services office.

Student Name _____ Date of Birth _____

VI. Brief Medical History (include injuries, operations, and medical conditions for which the student has received treatment) _____

Height _____ Weight _____ lbs. **Athletes:** Pulse _____

Pulse _____ Blood Pressure _____ After 15 hops _____

Vision: Right _____ Left _____ After 2 minutes _____

Condition of

Skin _____

Eyes: Right _____ Left _____ Ears: Right _____ Left _____

Nose _____

Throat _____ Teeth _____

Thyroid Gland _____

Heart (Murmur) _____

Lungs _____

Abdomen _____

Genito-urinary _____

Muscular Skeletal _____

Neurological _____

Is student receiving treatment from physician currently? Yes No

If yes, please specify _____

Is there loss/seriously impaired function of any paired organ? Yes No

If yes, please specify _____

Does this student have special dietary requirements? Yes No

If yes, please specify _____

On the basis of this examination, I approve the student's participation in

any physical education activity class with no restriction.

an adapted physical education program to exclude the following activities _____

no physical education activity classes for the following reason(s) _____

Health Care Provider (please print) _____

Health Care Provider's Signature _____ **Date** _____

Address _____ **Phone** (_____) _____

Student Name _____ Date of Birth _____

VII. Immunizations

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 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).

All dates must have month, day, and year.

Tetanus/Diphtheria/Pertussis: Must have one vaccine within the last 10 years

1. ____ / ____ / ____

MMR (Measles, Mumps, Rubella): Two doses required after first birthday. Live vaccine after May 1, 1971.

1. ____ / ____ / ____ 2. ____ / ____ / ____

OR

Measles: Two doses required after first birthday. Live vaccine available January 1, 1968.

1. ____ / ____ / ____ 2. ____ / ____ / ____

OR Date of Disease ____ / ____ / ____ OR Titer (copy of lab required) ____ / ____ / ____

Mumps: Two doses required after first birthday. Live vaccine available January 1, 1968.

1. ____ / ____ / ____ 2. ____ / ____ / ____

OR Date of Disease ____ / ____ / ____ OR Titer (copy of lab required) ____ / ____ / ____

Rubella: Two doses required after first birthday. Live vaccine available June 19, 1969.

1. ____ / ____ / ____ 2. ____ / ____ / ____

OR Date of Disease ____ / ____ / ____ OR Titer (copy of lab required) ____ / ____ / ____

Disease not accepted as proof of immunity for Rubella.

Meningococcal polysaccharide vaccine (Menactra MCV4) for Meningitis

1. ____ / ____ / ____

TB skin test is required within one year of admission to MacMurray College.

Date Given ____ / ____ / ____ Date Read ____ / ____ / ____

Results _____

The following immunizations are not required but recommended by the American College Health Association.

1. Hepatitis B:

Dose #1 ____ / ____ / ____ Dose #2 ____ / ____ / ____ Dose #3 ____ / ____ / ____

2. Varicella (Chickenpox): Disease

Yes No Date ____ / ____ / ____

OR Vaccination ____ / ____ / ____