Benedictine University®

STUDENT HEALTH SERVICES HEALTH FORM

All students are required to COMPLETE AND RETURN this health form.
All information is confidential and for Student Health Services use only.
NO HAND WRITTEN INFORMATION WILL BE ACCEPTED! THIS FORM MUST BE TYPED BEFORE PRINTING.

Term of Entry: Year: 20____ ☐ Fall ☐ Spring	☐ Resident ☐ Commuter	■ Male ☐ Female	☐ Undergraduate ☐ Graduate

Have you attended Benedictine University previously? ☐ Yes ☐ No If yes, last term enrolled _____

PERSONAL HISTORY *All information must be in English.*

Name _____ Benedictine ID# _____
(Last) (First) (Initial)

Home address _____ City _____ State _____ Zip code _____

Phone (Home) ( ) _____ (Work) ( ) _____ Date of birth ___/___/___

Name of parents, guardian or spouse _____

Who should we call in an emergency? Name _____ Phone (H) ( ) _____ (W) ( ) _____

MEDICAL HISTORY *(You may need to continue providing information on back of form.)*

Are you allergic to any medication? ☐ Yes ☐ No
If yes, please list: _____

Are you taking any medications (including oral contraceptives) on a regular basis? ☐ Yes ☐ No If yes, please list all prescriptions and the reason for taking these: _____

Do you currently have an illness or disability that requires medical treatment? ☐ Yes ☐ No If yes, please list: i.e., diabetes, seizure disorder, heart condition, ADD/ADHD, anxiety/depression or asthma, etc.: _____

Do you have any special needs with which Student Health Services or the Counseling Center can assist you or that may require follow up? ☐ Yes ☐ No
If yes, please explain: _____

Have you had any major illnesses (medical, surgical or psychiatric) in the past? ☐ Yes ☐ No
If yes, please list any hospitalization or operations: _____

FAMILY HISTORY

	Age	Occupation	Health Status	If no longer living, cause of death
Father				
Mother				
Siblings				

CONSENT FOR EMERGENCY TREATMENT

I consent to medical care and/or emergency treatment while I am enrolled as a student at Benedictine University. Care will be determined on the judgment of the doctors, nurses or psychological staff selected by the University. I agree to be responsible for any financial costs associated with any of the above mentioned care.

Date ___/___/___ Signature of student: _____ (Print) / _____ (Signature)

Date ___/___/___ Parent/guardian if student under 18: _____ (Print) / _____ (Signature)

ALL HEALTH RECORDS MUST BE COMPLETE AND ON FILE IN STUDENT HEALTH SERVICES BEFORE THE FIRST DAY OF CLASS FOR THE SEMESTER

PRINT, SIGN AND RETURN THIS FORM TO: Student Health Services • Benedictine University - 5700 College Rd., Lisle, IL 60532

Fax: (630) 829-6035 • Phone: (630) 829-6046

Benedictine University®

STUDENT HEALTH SERVICES IMMUNIZATION RECORD

YOU COMPLETE *ONLY* THE INFORMATION IN THIS SECTION:

Name: _____ **Date of Birth** _____ / _____ / _____

Benedictine ID# _____ **Country of Birth** _____

YOUR HEALTH CARE PROVIDER COMPLETES THE INFORMATION IN THIS SECTION:

No physical exam is required, however, Illinois law does require that all incoming students born **AFTER 1956** show documented proof of immunity to measles, rubella, mumps and tetanus/diphtheria. Please provide month, day and year for each dose administered. There are two options to meet this requirement: 1) Have the information completed and signed by your family doctor; or 2) Include a copy of your immunization record, which you can obtain from your high school health office.

REQUIRED IMMUNIZATIONS

If you have no verification of your immunization history, you will need to be revaccinated.

	Month	Day	Year		Month	Day	Year		Month	Day	Year
DPT (Primary Series of three)											
Tdap (tetanus – diphtheria acellular pertussis) One dose required within last 10 years.											
MMR – Two doses required after first birthday and at least one month apart. Also should be after 1968 or show proof of live vaccine given without gamma globulin.											
If MMR not given: list individually OR lab titers verified by doctor.											
Measles (Rubeola) – Two doses required both after first birthday and after 1968.											
Meningitis/Meningococcal Vaccine – One dose required.											
Mumps – Two doses required after first birthday.											
Rubella (German Measles) – Two doses required after the first birthday. Diagnosis is not accepted.											

NOT REQUIRED BUT RECOMMENDED

Hepatitis B series											

When immunization dates are written on this form, verification with a doctor's signature and office stamp is required.
When including a copy of your high school health record, no further verification should be needed.

_____ ____/____/____ OFFICE STAMP HERE:

Signature of health care provider (M.D., D.O., R.N.) verifying immunization record Date

FOR OFFICE USE ONLY
Incomplete Information: _____ Complete Information: _____ Date ____ / ____ / ____

Student Notified: ☐ in person ☐ voicemail ☐ spoke with on phone ☐ postcard ☐ email

ALL HEALTH RECORDS MUST BE COMPLETE AND ON FILE IN STUDENT HEALTH SERVICES BEFORE THE FIRST DAY OF CLASS FOR THE SEMESTER

PRINT, SIGN AND RETURN THIS FORM TO: Student Health Services • Benedictine University - 5700 College Rd., Lisle, IL 60532

Fax: (630) 829-6035 • Phone: (630) 829-6046