

MILLSAPS COLLEGE

WESSON HEALTH CENTER

Health History Form

Name _____
(Last) (First) (Middle)

Social Security # _____

Freshman year _____ Junior year _____

Sophomore year _____ Senior year _____

Trad. _____ Grad. _____ Spec. _____

TO THE APPLICANT AND THE PHYSICIAN:

The Health History Form is required for all entering students to complete registration. Please fill out the Health History Form. In order to render more efficient medical care to Millsaps students, the Wesson Health Center staff must have an accurate and comprehensive record of each student's present and past medical experience. Any condition which might affect the student's academic progress or require special attention should be reported. Effort will be made to facilitate continuation of a plan of treatment for the welfare of the student if specific instructions are furnished by the personal physician.

The Mississippi State Board of Health in conjunction with the Board of Trustees of the Institutions of Higher Learning require that all new and transfer students must show proof of documented history of two doses of MMR (measles, mumps, rubella) vaccine. It is VERY IMPORTANT that you complete your immunization information. Please note that documentation must be from a healthcare provider (family physician, health department, etc.)

This form is used as a permanent record during the student's entire time at Millsaps and is strictly confidential. If you have any questions please call the Office of Student Affairs at 974-1206.

THIS FORM MUST BE COMPLETED AND RETURNED BY AUGUST 1 TO: The Wesson Health Center, Millsaps College, 1701 N. State St Box 151062; Jackson, MS 39210. Do not turn it in to other campus offices.

MEDICAL HISTORY (To be completed by applicant)

Student's Name _____ Age _____ Sex _____
(Last) (First) (Middle)

Date of Birth _____ Marital Status _____

Parents' or Spouse's Name _____

Home Address _____ Telephone _____

City _____ State _____ Zip _____

Parents' Business Address (Mother) _____ Telephone _____

Parents' Business Address (Father) _____ Telephone _____

PAST MEDICAL HISTORY (Circle those which you have had and note date)

Measles (Red) _____ German Measles _____ Mumps _____ Chicken Pox _____

Hay Fever _____ Asthma _____ Rheumatic Fever _____ Diabetes _____

Hepatitis (A,B,C or other) _____ Epilepsy _____ Tuberculosis _____

Recurrent Tonsillitis _____ Blood Disorder/Anemia _____

Digestive Disorder _____ Bone/joint Problems _____ Psychological Condition _____

Other (specify) _____

REMARKS concerning the above _____

OPERATIONS/SERIOUS INJURIES – give dates _____

Do you wear glasses or contact lenses? (check) ___ No ___ All the time ___ Reading only ___ Outside only

Do you take any medicine or drugs? _____ If so, what and why? _____

Do you use tobacco products? (check) ___ Yes ___ No

Are you allergic to any medicine or drug? _____ If so, give details. _____

Are you now covered by hospitalization insurance? _____ If so, what company? Give the subscribers name.

_____ Insurance Number _____

Do you know of any reason why you will not be able to participate in all college activities, including athletics?

_____ If so, give reason. _____

EMERGENCY CONSENT FOR MINORS – Signatures Required

Students under 18 years of age cannot give legal consent to be treated in case a medical or psychological emergency arises. In such cases, are you willing to give permission for emergency treatment to be administered? ___ Yes ___ No

Signature of parent or guardian _____ Date _____

Signature of student _____ Date _____

Certificate of Immunization Compliance

Millsaps requires documentation of PPD (TB Skin Test) within the past year and 2 MMR's – 1st after 12 months of age, 2nd at 5 years old or later. **A Meningitis vaccine and a Tetanus booster are strongly recommended.** The Wesson Health Center staff **will** follow up on this to ensure documentation is provided.

Name of Student _____ Birthdate _____

Social Security Number _____

Address _____
Street City State Zip

| | Date Each Dose Was Given | | | | |
|--------------------|---------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Vaccine | 1st | 2nd | 3rd | 4th | 5th |
| DTP/DTaP/DT/Td | | | | | |
| Polio (OPV or IPV) | | | | | |
| Hep B | | | | | |
| MMR | | | | | |
| Varicella | | | | | |
| Other | | | | | |
| Other | | | | | |

TB Skin Test: Date Given _____ Date of Results _____ Positive Negative

If Positive, CXR Date _____ Results _____

Treatment _____

Health Dept. or Clinic Signature _____

Date Form Completed _____