JOHN A. SWENSON STUDENT HEALTH SERVICES
McCannel Hall, Room 100
2891 2nd Avenue N., Stop 9038
Grand Forks, ND 58202-9038
Phone: 701.777.4500 Fax: 701.777.4835

MANDATORY HEALTH HISTORY AND IMMUNIZATION FORM

Part I - To be completed by the Student (Please Print)

Last	*First*	*Preferred/Nickname*	*M.I.*
Address: *City* *State* *Country* *Zip*			
Date of Birth: / / *Sex :* M F *Other:* *Student ID#*			
Local Telephone Number: ( ) *Cellular Telephone Number:* ( )			
Next of Kin (Name): *Relationship to Student* *Telephone Number* ( )			
Address: *City* *State* *Country* *Zip*			

Part II VERIFICATION OF IMMUNIZATIONS – To be completed by Health Care Provider or Public Health Official

The North Dakota State Board of Higher Education Policy #506.1 ***requires*** all students enrolled in a course offered for credit at any institution must provide documentation of immunity against measles, mumps and rubella. TB skin testing is required of new students from all countries except those classified by U.S. health officials as "low risk for tuberculosis". Failure to comply may impact the student's ability to register for coursework at UND.
Students enrolled only in distance learning courses, courses taught off campus, continuing education or non-credit courses are exempt from this policy.

VACCINE	M/D/Y GIVEN	VACCINE	M/D/Y GIVEN	VACCINE	M/D/Y GIVEN
MMR 1		MMR 2			
Tetanus/Diphtheria					
Gardasil 1		Gardasil 2		Gardasil 3	
Hepatitis B 1		Hepatitis B 2		Hepatitis B 3	
Meningococcal					
Hepatitis A 1		Hepatitis A 2			
Polio IPV/OPV					
Varicella					
Pneumococcal					
TB Skin Test	Two-Step Indicated? Y or N	Date/Time Placed #1	Date/Time Read/mm	Date/Time Placed #2	Date/Time Read/mm

Signature of Dr. or Public Health Official:____ ***Date:***_____________

An Official/Signed Immunization Record may be substituted for this section.

If you have medical or religious reasons for not receiving the required vaccinations, please complete appropriate exemption below:

Medical exemption: The student named above does not have one or more of the required immunizations because he/she has (check all that apply and fill in the appropriate blanks):

- ☐ A medical problem that precludes the ____ vaccine(s).
- ☐ Not been immunized because of a history of ____ disease(s).
- ☐ Shown laboratory evidence of immunity against ____

Healthcare Provider signature ____ **Date** ________________

Conscientious Exemption: *I hereby certify by notarization that immunization against* ___________________________________ *is contrary to my conscientiously held beliefs.*

Student's signature ____ Date ________________________

Subscribed and sworn before me on ________________ day of ___________________________ 20 _________

Signature and seal of notary ____

Part III HEALTH HISTORY - To be completed by the Student

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO	
Medication	**Allergic Reaction Experienced**

☐ **Allergies/Environmental Sensitivities:**____
Please list

☐ **Latex Allergy**

If you have had any of the following, please check 'yes'. Explain YES answers in the space provided.

SKIN	YES	**RESPIRATORY**	YES	**GENITOURINARY**	YES	**MUSCULOSKELETAL**	YES	**ENDOCRINE**	YES
Acne		Asthma		Urinary Tract Infection		Arthritis		Diabetes	
Other Skin Problems		Chronic Cough		Kidney Stones or Disease		Fracture or Dislocations		Sudden Weight Change	
EYES		Bronchitis or Pneumonia		Sexually Transmitted Infection		Back/Disc Problems		Thyroid Problem/Disease	
Eye Injury/Disease		**CARDIAC**		**WOMEN:**		Scoliosis		**HEMATOLOGIC**	
EAR/NOSE/THROAT		High Blood Pressure		Menstrual Irregularity		**NEUROLOGICAL**		Anemia/low iron	
Hearing Loss/Deafness		High Cholesterol		Severe Cramps		Migraines		Sickle Cell Trait/Disease	
Frequent Ear Infections		Irregular Heart Rate		Abnormal Pap Smear		Frequent Headaches		Clotting Disorder	
Perforated Eardrum		Heart Murmur		Breast Problems		Concussion/Head Injury		**INFECTIOUS DISEASE**	
Repeated Nosebleeds		History of Palpitations		Pelvic Inflammatory Disease		Dizziness/Fainting		Mononucleosis	
Sinus Infections		Chest Pain		**MEN:**		Insomnia		Whooping Cough	
Frequent Sore Throats		**GASTROINTESTINAL**		Epididymitis		Neuromuscular Disorder		Meningitis	
Tonsils/Adenoids Surgery		Stomach Problems/Ulcer		Testicular Torsion		Weakness/Paralysis		**OTHER PROBLEMS**	
DENTAL		Requires Special Diet		Loss/Damaged Testicle		ADD/ADHD			
Bleeding Gums		Hepatitis		Undescended Testicle		Seizures/Epilepsy			
Poor Teeth		Gallbladder Problems		Testicular Cancer		**MENTAL HEALTH**			
		Irritable Bowel Problems				Anxiety Disorder			
		Hemorrhoid Problems				Depression			
		Hernia				Anorexia and/or Bulimia			
						Suicide Attempt			

DESCRIBE details for each 'yes' with dates. Please use an extra page if space is not adequate.

____
____
____

Do you have any other health related conditions not listed above?____________________________________
____

☐ Hospitalization/Surgeries (list date/purpose or type)____
____

FAMILY HISTORY

	Age	Health Problems	Age at Death	Cause of Death
Mother				
Father				
Siblings				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

LIST ALL CURRENT MEDICATIONS *Please include all over-the-counter medications, supplements and alternative therapies (herbs, aroma, etc)*					
Medication	**Dose/Route**	**Purpose**	**Medication**	**Dose/Route**	**Purpose**

Part IV HEALTH INSURANCE INFORMATION – To be completed by the Student ****Please attach a copy of your health insurance card (*front & back*)****			
Name of Insurance Co./address ***Policy #***		*Policy #*	
Policy Holder	*Last Name:*	*First Name:*	*MI:*
Policy Holder DOB	/ /	*Relationship to Student:*	

SIGNATURES REQUIRED:

- **I certify to the best of my knowledge that the information on this form is complete and correct.**

  STUDENT NAME (PLEASE PRINT) ______________________________

  STUDENT SIGNATURE: ______________________________ DATE _______/_______/_______

- **CONSENT FOR MINOR (UNDER 18 YEARS OF AGE):** I give my permission for medical treatment for my daughter/son if accident/illness should occur while she/he is a student at the University of North Dakota. This would include referral to a local hospital which may result in her/his hospitalization, anesthesia, and surgery should it be necessary and I am unable to be reached.

  PARENT/GUARDIAN'S NAME (PLEASE PRINT) ______________________________ RELATIONSHIP ____________________

  SIGNATURE OF PARENT/GUARDIAN ______________________________ DATE _______/_______/_______

  STUDENT NAME ______________________________ (PRINT)

Please return completed form to:
Student Health, McCannel Hall, Room 100
2891 2nd Avenue North, Stop 9038
Grand Forks, ND 58202-9038
or
Fax: (701) 777-4835