



Policy Number \_\_\_\_\_

Please list your emergency contact:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone number (w) \_\_\_\_\_ (h) \_\_\_\_\_

### **Health History**

Check all items that apply

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> Kidney disease       |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Obesity              |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Sickle Cell Disease  |
| <input type="checkbox"/> Fainting/dizziness     | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Frequent headaches     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Urinary disturbances |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Vision disturbances  |
| <input type="checkbox"/> High Blood Pressure    |   |

Physical/ Learning disabilities: check all that may apply **Note: Students are responsible for requesting accommodations (living or classroom) from and providing documentation to the Office of Student Development.**

- |  |  |
|--|--|
| <input type="checkbox"/> Blindness/vision loss | <input type="checkbox"/> Paralysis of arms |
| <input type="checkbox"/> Hearing impairment    | <input type="checkbox"/> Paralysis of legs |
| <input type="checkbox"/> Learning disability   |  |

Allergies: check all that apply

- |   |
|---|
| <input type="checkbox"/> Aspirin                  |
| <input type="checkbox"/> Antibiotics – name _____ |
| <input type="checkbox"/> Bee sting                |
| <input type="checkbox"/> Other – name _____       |

**Answer the following questions:**

1. Do you have any health condition that could prohibit your participation in any school-sponsored activity?

- Yes       No

If yes, please explain your limitation

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If you are currently prescribed medication from your physician , please list it below

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Is there anything else you would like to share about your medical/health condition?

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**Section B : To be completed by all students born after 1956: Must be accompanied by proof from physician**

Measles ( Rubeola) TWO vaccinations after 12 months of age  
Date of dose 1 \_\_\_\_\_ Date of dose 2 \_\_\_\_\_  
(After 1968)

Mumps One immunization after 12 months of age  
Date of dose 1 \_\_\_\_\_

Rubella One immunization after 12 months of age  
Date of dose 1 \_\_\_\_\_

Tetanus/Diphtheria Immunization within the last 10 years  
Date of dose \_\_\_\_\_

Meningococcal Vaccine (Meningitis) \_\_\_\_\_  
**\*\*Must be accompanied by signed waiver**

**Section C: To be completed ONLY by International Students: Must be accompanied by proof from physician**

**Tuberculosis Skin Test must have been completed within the last 6 months**

**Date of skin test \_\_\_\_\_ Result (\_\_\_\_) mm. Induration**

**If skin test was positive must have chest X-ray**

**Date of chest X-ray \_\_\_\_\_ Result : Positive \_\_\_\_\_ Negative \_\_\_\_\_**

**To be completed by all students:**

A letter for either religious or medical reasons must accompany exemptions to any of the above vaccinations. If a medical reason, a letter from a physician must accompany this from.

I, the undersigned, understand that this information will be held in strictest confidentiality among members of the Residence Life staff at Capitol College. It will be referred to emergency personnel in case of an urgent matter while I am enrolled in on campus housing. I agree that all the above information is correct and up to date to the best of my knowledge.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_