MANDATORY HEALTH HISTORY AND IMMUNIZATION FORM

Please return via fax (701) 777-4835
OR mail to: Student Health, McCannel Hall Room 100
2891 2nd Avenue North, Stop 9038,
Grand Forks, ND 58202-9038

Parts I/III/IV: To be Completed by the Student (Please Print)
Part II: To be Completed by Health Care Provider or Public Health Official

☐ Undergraduate ☐ Graduate ☐ Transfer Year_____ **EMPL ID**_____

Last *First*
Middle Initial

Address: *City* *State* *Country*
Zip

Date of Birth: / / *Sex :* M F *Social Security Number:*

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

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. Failure to comply may impact the student's ability to register for coursework at UND.

** Required Immunizations* ***Required for some degrees* ****Recommended*

VACCINE	M/D/Y GIVEN	VACCINE	M/D/Y GIVEN	VACCINE	M/D/Y GIVEN
MMR 1 *		**MMR 2***			
Hepatitis A 1***		**Hepatitis A2**			
Hepatitis B1/*****		**Hepatitis B2**		**Hepatitis B3**	
Tetanus/Diphtheria **/***					
Meningococcal ***					
Polio IPV/OPV **					
TB Skin Test**	Two-Step Indicated? Y or N	Date/Time Placed	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 make your statement on a separate sheet of paper and attach to this form.

Part III HEALTH INSURANCE INFORMATION

****Please attach a copy of your health insurance card (*front & back*)****

Name of Insurance Co.			
Policy Holder	*Last Name:*	*First Name:*	*MI:*
Policy Holder DOB	/ /	*Relationship to Student:*	

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO		
Medication	**Used For What Purpose**	**Allergic Reaction Experienced**

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

☐ **Latex Allergy**

Part IV: *Please check all that apply to you:*

☐ Short of Breath ☐ Skin Problems ☐ Vision Problems ☐ Dizziness ☐ Head Injury

☐ Headaches/Migraines ☐ Anxiety ☐ Stress ☐ Fatigue ☐ Insomnia

☐ Fainting ☐ Frequent Colds ☐ Sinus Problems ☐ Frequent Sore Throat ☐ Pneumonia

☐ Tobacco Use ☐ Alcoholism ☐ Drug Use ☐ Anemia ☐ Thyroid

☐ High Cholesterol ☐ High Blood Pressure ☐ Heart Murmur ☐ Rheumatic Fever ☐ Heart Disease

☐ Asplenia ☐ Back Problems ☐ Kidney Disease ☐ Urinary Tract Infections

☐ Depression ☐ Eating Disorders ☐ Seizures/Epilepsy ☐ Weakness/Paralysis ☐ Stroke

☐ Breast Cysts/Mass(es) ☐ STDs/STIs ☐ Tuberculosis ☐ HIV/AIDS

☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Cancer

☐ Menstrual Problems ☐ Endometriosis ☐ Prostate Problems ☐ Erectile Issues

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

_____

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

_____

Have you ever sought out treatment for alcohol and/or drug use? ☐ Yes ☐ No

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**

I attest that the information provided is correct to the best of my knowledge.

6/6/2006

_____ _____

Signature Date