UNIVERSITY OF NORTH DAKOTA
JOHN A. SWENSON, M.D. STUDENT HEALTH SERVICES
MANDATORY HEALTH HISTORY AND IMMUNIZATION FORM

Please return to Student Health, P.O. Box 9038, GF, ND 58202

☐ Fall Enrollment ☐ Spring Enrollment ☐ Summer Enrollment Year________

PART 1 – TO BE COMPLETED BY STUDENT (please print) **NAID #**________________________

Last	*First*	*Middle Initial*		
Address:	*City*	*State*	*Country*	*Zip*
Date of Birth: / /	*Sex : M F*	*Social Security Number:*		
Next of Kin Address:	*City*	*State*	*Country*	*Zip*
Local Telephone Number: ( )	*Parents Telephone Number: ( )*			

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 in accordance with this policy. Failure to comply may impact the student's ability to register for coursework at the University of North Dakota.

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

VACCINE	M/D/YR GIVEN	VACCINE	M/D/YR GIVEN	VACCINE	M/D/YR GIVEN
MMR 1 *		**MMR 2** *			
Hepatitis B 1/*** &/or Hepatitis A 1**	Hep B1	Hepatitis B 2 Hepatitis A 2	Hep B2	Hepatitis B 3	
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

____ **Date:** __________

****Signature Validation of Immunization by Physician or Public Health Authority/or Attached Official Documentation Record***

**** 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. Thank you.***

HEALTH INSURANCE INFORMATION

Name of Insurance Company				
Address	*Street:*	*City:*	*State:*	*Zip:*
Insurance Company Phone #	*Area Code ( )*			
Policy Holder	*Last Name:*	*First Name:*	*MI:*	
Policy Number				
Relationship to Student	*Self:*	*Spouse:*	*Parent:*	*Other (explain):*

**** Please attach a front and back copy of your health insurance card****

6/12/03

Please check all that apply to you:

☐ Alcoholism ☐ Allergies ☐ Short of Breath ☐ Diabetes ☐ Headaches

☐ Tobacco Use ☐ Seasonal Allergies ☐ High Cholesterol ☐ Kidney Disease ☐ Migraines

☐ Drug Use ☐ Environmental Sensitivities ☐ High Blood Pressure ☐ Urinary Tract Infections ☐ Vision Problems

☐ Severe Worry ☐ Latex Allergies ☐ Heart Murmur ☐ Prostate Problems ☐ Dizziness

☐ Stress ☐ Asthma ☐ Rheumatic Fever ☐ Erectile Issues ☐ Head Injury

☐ Insomnia ☐ Frequent Colds ☐ Heart Disease ☐ Menstrual Problems ☐ Seizures

☐ Fatigue ☐ Sinus Problems ☐ Stroke ☐ Anemia ☐ Epilepsy

☐ Depression ☐ Chronic Pneumonia ☐ Weakness/Paralysis ☐ Endometriosis ☐ Fainting

☐ Eating Disorders ☐ Frequent Sore Throat ☐ Arthritis ☐ Breast Mass(s) ☐ HIV/AIDS

☐ Skin Problems ☐ Lung Disease ☐ Back Problems ☐ Breast Cysts ☐ STDs

☐ Cancer ☐ Tuberculosis ☐ Hospitalizations* ☐ Surgeries*

* List surgeries, hospitalizations:____

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

* Do you have a spleen? ☐ Yes ☐ No

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

LIST ALL CURRENT MEDICATIONS

Please include over-the-counter and any alternative therapies (herbs, aroma, etc)

Medication	Dose/Route	Medication	Dose/Route	Medication	Dose/Route

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO

Medication	Used For What Purpose	Allergic Reaction Experienced

PREADMISSION INFORMATION

Date	Age	Height	Weight	Blood Pressure	Tobacco Use Y/N	Comments (health concerns, etc)

____

Student Signature **Date**

****STOP HERE** FOR OFFICE USE ONLY****

HEALTH ASSESSMENTS AT STUDENT HEALTH SERVICES

Date	*Age*	*Height*	*Weight*	*BMI*	*Blood Pressure*	*Pulse*	*Tobacco Use? Y or N*	*Comments*