SOUTHWEST
MINNESOTA STATE UNIVERSITY

HEALTH SERVICES

# REPORT OF MEDICAL HISTORY

As a student, it is your responsibility to provide an accurate past medical history.
All information is held confidentially within Health Services at Southwest Minnesota State University.
*Please complete before entering college.*

*Last Name (Family Surname)* *First Name (Given-Personal)* *Middle Name*

*Home Address (Number and Street)* *City or Town* *State* *Zip* *Country* **Date of Birth (MM/DD/YY)*

*Emergency Contact Name and Relationship* *Home Telephone*

*Emergency Contact Address* *Business Telephone*

Gender: Male [ ] Female [ ]

**Social Security Number of Student*

**Many colleges/universities use Social Security numbers for student identification purposes on student records. Providing your Social Security number, gender, and date of birth is voluntary. If you do not provide this number, this information will still be processed. This data is requested for purposes of administration, program evaluation, and consumer and alumni data. Your number also may be used to create summary information about MnSCU programs through data matches with other state agencies.*

**SEMESTER ENTERING:** *Circle Term*: Fall Spring Summer Session I or II *Year:* 20____

**HAVE YOU OR ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING?**

| AILMENT | YES | NO | RELATIONSHIP | AILMENT | YES | NO | RELATIONSHIP |
|---|---|---|---|---|---|---|---|
| Tuberculosis | | | | Diabetes | | | |
| Kidney Disease | | | | Heart Disease | | | |
| Arthritis | | | | Stomach Disease | | | |
| Asthma | | | | Hay Fever | | | |
| Seizure Disorder | | | | Cancer | | | |

**PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in the space on the back side of this sheet.**

| HAVE YOU HAD: | YES | NO | HAVE YOU HAD: | YES | NO | HAVE YOU HAD: | YES | NO | HAVE YOU HAD: | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Chicken Pox | | | Insomnia | | | Pain/Pressure in Chest | | | Gallstones | | |
| Malaria | | | Frequent Anxiety | | | Chronic Cough | | | Recurrent Diarrhea | | |
| Gum/Tooth Trouble | | | Depression | | | Heart Palpitations | | | Rupture, Hernia | | |
| Sinusitis | | | Nervousness/Worry | | | High/Low Blood Pressure | | | Recent Weight Gain | | |
| Eye Trouble | | | Recurrent Headaches | | | Rheumatic Fever | | | Recent Weight Loss | | |
| Ear/Nose/Throat Trouble | | | Recurrent Colds | | | Heart Murmur | | | Dizziness, Fainting | | |
| **Surgery:** | | | Head Injury with Unconsciousness | | | Joint Disease | | | Weakness, Paralysis | | |
| Appendectomy | | | | | | Joint Injury | | | Seizures | | |
| Tonsillectomy | | | Hay Fever, Asthma | | | "Trick" Joint (Knee, Shoulder) | | | Venereal Disease | | |
| Hernia Repair | | | Tuberculosis | | | Back Problems | | | Albumin/Sugar in Urine | | |
| **Immunization Data:** *(Most recent date)* | | | Shortness of Breath | | | Tumor or Cyst | | | AIDS or HIV | | |
| Measles/Mumps/Rubella | | | **Allergic Reactions:** | | | Cancer | | | **Menstrual History:** | | |
| Tetanus/Diphtheria Year:_____ | | | Penicillin | | | Jaundice | | | Age at Onset | | |
| Hepatitis B No Yes/Year:_____ | | | Sulfonamides | | | Stomach Problems | | | Irregular Periods | | |
| Meningococcal No Yes/Year:_____ | | | Serum | | | Intestinal Problems | | | Severe Cramps | | |
| HPV No Yes/Year:_____ | | | Foods (which) | | | Urinary Problems | | | Excessive Flow | | |
| Varicella No Yes/Year:_____ | | | | | | Gallbladder Trouble | | | Other: | | |
| | | | Other: | | | Recurrent Infections | | | | | |

**Height:** _____Inches (_____Centimeters) **Weight:** _____lbs. (_____Kilograms)

*Continue on the other side.*

**Please answer the following questions (Give dates and details):**

1. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 (five) years, other than routine?_____

   _____

2. Have you had any major injuries or operations? [ ] YES [ ] NO
   If YES, what kind and when: _____

   _____

3. Has your physical activity been restricted during the past 5 (five) years? [ ] YES [ ] NO
   If YES, describe: _____

   _____

4. Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problem or chemical dependency? [ ] YES [ ] NO
   If YES, what kind and when: _____

   _____

5. Are you taking medication regularly? [ ] YES [ ] NO
   If YES, what kind and when: _____

   _____

6. Do you have any physical disabilities such as paralysis, loss of vision, impaired hearing, etc.? [ ] YES [ ] NO
   If YES, describe: _____

   _____

7. List below any hospital, illness or health insurance you carry. Please indicate policy numbers. Southwest Minnesota State University recommends all students carry health insurance.

   _____

   _____

   _____

   Additional Comments or Information: (If more space is needed, please attach additional sheets identified with name and social security number.)

## TREATMENT CONSENT AND RELEASE

In case of accident or illness, I give the University and its representative(s) full permission to secure medical, dental and/or surgical care which may include transport to a doctor or hospital of their choice, injection, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all off-campus medical costs and fees, including costs and fees for all emergency medical treatment and transportation, in these events, I understand and agree that the University does not have any liability or responsibility for any injury or damage that may arise from such medical, dental and/or surgical care.

Student's Signature_____Date:_____

**If the student is under 18 years of age at the time of enrollment, a parent or guardian's signature is required before medical treatment can be provided.**

Parental Signature_____Date:_____

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HEALTH SERVICES

# INFORMATION REGARDING MANDATORY REQUIREMENT FOR ENROLLMENT

If you plan to enroll at Southwest Minnesota State University (SMSU), you are required by Minnesota Law (M. S. 135A.14) to provide us with the month, day and year you were immunized against diphtheria, tetanus, measles, mumps and rubella. Fill in these dates on the Student Immunization Record printed on the back of this letter. Please be sure to use your full name, birth date and Mustang ID.

SMSU Health Services does not provide immunizations. You may obtain necessary immunizations from your family physician/clinic or your local Public Health office. When all required immunizations have been obtained, complete and return the form with the month, day and year that you received the immunizations.

To find out if you are adequately immunized against these diseases, check with your parents, family physician, or school immunization records. Call your high school or doctor's office for assistance if necessary.

An immunization may not be medically advisable for certain persons. If this applies to you, or if you have had any of these diseases, Part 4 of the immunization form must be completed/signed by your doctor and returned to SMSU Health Services.

Some people may be exempt from immunizations based on their religious or other conscientiously held beliefs. If you request a conscientious exemption, you must have a notary witness your signature in Part 5 of the form before returning it to SMSU Health Services.

You are legally required to supply the information requested, according to the instructions contained on the form. A student who has submitted a compliant immunization record to another Minnesota post-secondary school may complete Part 2.

Anyone enrolled at SMSU who fails to submit the required information within 45 days of the beginning of the term will not be allowed to remain enrolled at SMSU.

If you have questions about the immunization law or your status of compliance, please contact Health Services at 507-537-7202.

COMPLETE THE STUDENT IMMUNIZATION RECORD PRINTED ON THE BACK OF THIS LETTER AND RETURN IMMEDIATELY TO:

**SMSU Health Services**
**Bellows Academic 158**
**1501 State Street**
**Marshall, MN 56258**

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# IMMUNIZATION RECORD FOR STUDENTS ATTENDING POST-SECONDARY SCHOOLS IN MINNESOTA

| Student Name (Last, First, MI): | Date of Birth: | Mustang ID Number: | Enrollment Date (Mo/Yr): |
|---|---|---|---|
| | | | |

*** Please make a copy of this form. Your completed form will NOT be accessible for future release or duplication.**

Minnesota Law (M.S. 135A.14) requires proof that all students born after 1956 are vaccinated against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions (see below). Any non-exempt student who fails to submit the required information within 45 days after the first enrollment cannot remain enrolled. This form is designed to provide the school with the information required by the law and will be available for review by the Minnesota Department of Health and the local health agency.

ALL STUDENTS: Return this completed form to SMSU Health Services, BA 158, 1501 State Street, Marshall, MN 56258
Fax: (507) 537-7259, Phone: (507) 537-7202, www.smsu/edu/go/healthservices

☐ Check here if you were born before 1957 for the age exemption. You don't have to complete the rest of this form.
*All other students who are not age-exempt: Complete the section below that applies to you.*

**PART 1:** *Students graduating from a Minnesota high school in 1997 or later*

I have previously met the MMR (measles, mumps, rubella) and Td (tetanus, diphtheria) requirements because I graduated from a Minnesota high school in 1997 or later.

Name of high school _____ City: _____ Date of graduation: _____

Student's Signature _____ Date _____

**PART 2:** *Transfer student from another Minnesota college*

I am exempt from these requirements because my admission records indicate I have met the requirements as an enrolled student in another post-secondary school in Minnesota. Name of previous Minnesota College: _____

Student's Signature _____Date _____ Dates enrolled from _____ to _____

**PART 3:** *Students who graduated from a Minnesota high school before 1997 or students from out of state*

| | Mo/Day/Yr (most recent date please) |
|---|---|
| Tetanus/diphtheria (Td) - at least one dose **required within past 10 years** | |
| Measles/Mumps/Rubella (MMR) - at least one dose required given ≥ 12 months of age | |

I certify that the above information is a true and accurate statement of the dates on which I was vaccinated.
Student's Signature _____ Date _____

**PART 4 & 5:** *Other exemption(s): *Note special signature requirements*

**Part 4: Medical Exemption:** The student named above lacks one or more of the required immunizations because he/she:
*(Check all that apply and fill in the appropriate blanks)*

☐ has a medical problem that precludes the_____vaccine
☐ has not been immunized because of a history of_____ disease
☐ has laboratory evidence of immunity against_____disease

*PHYSICIAN'S SIGNATURE _____Date _____

**Part 5: Conscientious Exemption:** I hereby certify by notarization that immunization against_____ disease is contrary to my conscientiously held beliefs.

Student's Signature _____ Date _____

Subscribed and sworn to before me this_____day of_____, 20_____

*NOTARY SIGNATURE_____

*** Please make a copy of this form.**
**Your completed form will NOT be accessible for future release or duplication.**