Drake
UNIVERSITY

Return completed forms to:
Drake University Student Health Center
3116 Carpenter Ave. Des Moines, IA 50311
Phone: 515-271-3731
Fax: 515-271-1855

Drake University Medical History Form

The Drake University Student Health Center requests this confidential information for the purpose of providing patient care. Persons outside the student health service are not provided this information without the patient's written consent.

To help us better serve you, please provide a copy of your insurance card.

Please read and complete this document carefully. Failure to complete as instructed could result in future class registration delays. Please send completed health form/immunization documents directly to the Student Health Center at the above address by the second week after classes start. Please provide a copy of your insurance card. **Send all records at the same time/in the same envelope.**

Student's Name: _____ Student ID No.: _____
Last First Middle

Birth Date: _____ Current age:_____ Sex: ____ M ____ F Country of Birth: _____

Home Address: _____
Street City State ZIP

Home Phone: _____ Cell: _____ Email: _____

Admission (Circle) Spring Summer Fall Year: _____ Major: _____

In case of emergency, please contact

1. Contact Name: _____ Relationship: _____
   Cell Phone: _____ Home: _____ Work: _____

2. Contact Name: _____ Relationship: _____
   Cell Phone: _____ Home: _____ Work: _____

Medical History—Family

	Age	Occupation	Health Status	Deceased
Father				
Mother				
Siblings				

Have any of your relatives had any of the following?	Yes	No	Relation		Yes	No	Relation
Arthritis				Heart Disease			
Asthma, Hay Fever				High Blood Pressure			
Cancer				Mental Health Disorder			
Depression				Substance Abuse			
Diabetes				Tuberculosis			
Seizures				Sickle Cell Anemia			
Kidney Disease				Other			

Parental Consent for Minor:
The above named student has my permission to receive services at the Drake Student Health Center. I understand that employees of the UnityPoint Health System staff the Drake Student Health Center in a contractual agreement with Drake University. Permission for my child to receive services shall remain in effect until my child is 18 years of age. At that time, I understand that my child will no longer need my permission to receive services. (A parent or guardian can revoke this permission at any time.)

Signature of Parent/Guardian if student is a minor: _____ Date: _____

Student's Name: _____

Medical History—Personal: Please check if you have or have had any of the following:

Have you had or do you currently have:	Yes	No		Yes	No		Yes	No		Yes	No
ADD/ADHD			Drug/alcohol abuse			Mononucleosis			Tuberculosis		
Anemia			Ear/nose/throat conditions			Mumps			Urinary tract infections		
Anxiety			Eating disorder			Pneumonia			Weakness: paralysis		
Asthma			Eye conditions			Recurrent headaches/ migraines			Weight gain/loss		
Back pain			Frequent indigestion			Seizure disorder			Other conditions:		
Cancer			Gallbladder disease			Sexually transmitted infection					
Chest pain/pressure			Head injury/ concussion			Shortness of breath					
Chicken pox			Heart murmur			Sickle cell trait					
Chronic cough			Heart palpitation			Sinusitis			**Female students:**		
Depression			High/low blood pressure			Sleeping difficulty			Irregular periods		
Diabetes			Jaundice/Hepatitis			Stomach/intestinal/ ulcer issues			Pregnancy		
Dizziness/fainting			Joint injury			Thyroid disorder			Severe cramps		

Please explain any "yes" answers in the Personal Medical History:

	Yes	No	Comments
Have you had any illness/injury or surgery which required hospitalization?			
At any time, have any of your activities been restricted due to illness, injury, etc.? Please explain if yes.			
Have you ever experienced any personal or emotional difficulties which required professional attention or hospitalization?			If you would like more information about mental health services you may contact Drake Counseling Center at 515-271-3864.

Please list any medications you are currently taking:

Please list any allergies and **reactions** to include medications, food, and environmental:

Drake University Student Health Immunization History

Obtain copies of your immunization records and attach to this form.

Examples of acceptable documents include:
- Copies of physician office or health department immunization records
- Copies of high school or previous college immunization records

(Please fill in the dates below.)

Student Name: _____ DOB: _____

Required immunizations

MMR (Measles, Mumps, Rubella) – 2 DOSES REQUIRED:

Proof of immunity to MMR is a requirement for registration for classes. This requirement is fulfilled if you meet one of the following criteria:

- birth date before 1957
- **or** received two doses of MMR vaccine (provide both dates)
  1: _____/_____/_____ 2: _____/_____/_____
  second dose must be at least 28 days after first dose.
- **or** received two doses of Measles, Mumps, Rubella vaccine (provide both dates)
  Measles 1: _____/_____/_____ 2: _____/_____/_____
  Mumps 1: _____/_____/_____ 2: _____/_____/_____
  Rubella 1: _____/_____/_____ 2: _____/_____/_____
- **or** provide to Student Health Services copies of original lab reports of MMR titers that verify immunity to these diseases

Recommended Immunizations (but not required)

Tetanus/Diptheria/Pertussis (TDAP):

Booster (within past 10 years): _____

Varicella: (birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets requirement)

History of the disease: _____ Yes _____ No

Immunization: Dose 1: _____ Dose 2: _____

Hepatitis B Series:

Dose 1: _____ Dose 2: _____ Dose 3: _____

Hepatitis A Series:

Dose 1: _____ Dose 2: _____

Gardisal (HPV vaccine):

Dose 1: _____ Dose 2: _____ Dose 3: _____

Strongly Recommended if Living on Campus

Meningitis (Menactra):

Meningitis is an infection of the fluid surrounding the brain and spinal cord that is caused by a virus or bacteria. Bacterial meningitis can be severe and cause organ damage and death. **The Meningitis vaccine is recommended for college freshmen living in residence halls.**

To make an informed decision about receiving the vaccine it is important to read the information provided at the following websites:

www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html
or
www.acha.org/topics/meningitis.cfm

Dose 1: _____

Dose 2: _____ (if Dose 1 was given before age 16)

If you have **not** received the meningitis vaccine you may sign a waiver: I am 18 years of age or older or the parent of a minor child. Drake University has provided me information explaining the risks of meningococcal disease and I am aware of the effectiveness and availability of the vaccine. I do not choose to get the meningococcal vaccine at this time.

_____
Signature of student or parent/guardian

_____
Date

To validate this form, have it signed and dated by your health care provider or authorized immunization official or provide a copy of your immunization record.

Name of Health Care Provider: _____ Signature: _____

Address: _____ Date (month/day/year): _____/_____/_____

Drake University Student Health Center
Tuberculosis Screening Form

Patient Name: _____ Phone: _____

DOB: _____

All students are required to complete the below questionnaire. **Students from countries that have a high incidence of TB disease are required to have a TB skin test upon arrival at Drake University.** Visit *www.stoptb.org/countries/tbdata.asp* for a map of countries' incidence rates. High incidence is considered more than 10 cases per 100,000 populations.

Check any that may apply:

_____ From or have lived for two months or more in Asia, Africa, Central or South America, or Eastern Europe

_____ Have been diagnosed with a chronic medical condition that may impair your immune system

_____ A health care worker/volunteer in a nursing home, prison, residential institution, or hospital

_____ Have symptoms of active tuberculosis: unexplained weight loss or weakness, coughing up blood, night sweats

_____ Contact with a person known to have active tuberculosis

_____ Productive cough for more than two weeks

(If any of the above apply, TB screening is required)

_____ **None of the above apply (no TB test required)**

_____ Have you ever been vaccinated with BCG?

Attention international students:

- **DO NOT HAVE A TUBERCULOSIS SKIN OR BLOOD TEST DONE PRIOR TO COMING TO THE UNITED STATES. ALL TB SCREENING MUST BE DONE IN THE UNITED STATES.**
- Do not have a BCG vaccination prior to coming to Drake University.
- If you are required to have a chest x-ray, it must be done in the United States within one month of starting at Drake University.
- If you have had a positive TB skin test **OR** have been treated for TB infection or disease, bring a copy of your treatment report written in English.

Date: _____ Time: _____

PPD 0.1 ml administered on the _____ forearm.

Manufacturer: _____ Lot No.: _____ Expires: _____

Staff Signature: _____

The test must be observed 48 to 72 hours after being administered by an approved medical professional familiar with reading and recording test results.

PPD read on: _____ Time: _____

Results are of _____ mm in duration.

Read by: _____

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