



Kentucky Christian University

Student Health Information

For Term Beginning

Fall _____

Spring _____

The information on this form is important to the entering student's college health record. Pages 1 and 2 should be filled out by the student with the help of his/her parents. Pages 3 and 4 should be completed by the family physician during and after the required physical exam and immunizations. Send the entire completed form to: Kentucky Christian University, Student Services Office, 100 Academic Parkway, Grayson, Kentucky 41143-2205.

Today's Date _____ / _____ / _____
Month Day Year

Student's Date of Birth _____ / _____ / _____
Month Day Year

Student's Full Name _____ SSN _____

Home Address _____ Home Phone (_____) _____

City _____ State _____ Zip _____ E-Mail _____

Marital Status Single Married Divorced Widowed

PARENT INFORMATION (Custodial Parent/Step-Parent/Guardian)

Father's Name _____

Mother's Name _____

Address _____
If different from your home address

Address _____
If different from your home address

City _____

City _____

State _____ Zip _____

State _____ Zip _____

Employer _____

Employer _____

Employer Phone (_____) _____

Employer Phone (_____) _____

SPOUSE INFORMATION (For married residential and commuter students)

Spouse Name _____

Employer _____ Employer Phone (_____) _____

In case parents/spouse are unable to be notified in the event of an emergency, we need another contact person

Contact other than parents/spouse _____

Relationship _____ Phone Number(s) _____

Family Physician _____ Phone (_____) _____

Address _____

Health Insurance Company _____ Phone (_____) _____

Address _____

Policy Number _____ Group Number _____

Policy Holder _____

TO BE FILLED OUT BY STUDENT OR PARENT/GUARDIAN

(1) FAMILY HISTORY

	Name	Age	Health Status	If Deceased, List Year/Cause
Father				
Mother				
Siblings				

(2) CURRENT MEDICATIONS

Drug Name	Dose and Frequency	Reason

(3) ALLERGIES (MEDICATIONS, FOODS, ENVIRONMENTAL)

Allergic To	Reaction	Treatment

(4) MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Measles			Fainting			Head Injury		
Mumps			Asthma			Sinusitis		
Chicken Pox			Shorness of Breath			Frequent Strep		
Tuberculosis			Lung Disease			Mononucleosis		
High B/P			Stomach Problems			Broken Bones		
Low B/P			Crohn's Disease			Kidney Problems		
Rheumatic Fever			Bowel Problems			Back Pain/Injury		
Heart Murmer			Cancer			Difficulty Sleeping		
Heart Problems			Bone/Joint Deformity			Sleep Walking		
Diabetes			Frequent Headaches			Emotional Disorders		
Low Blood Sugar			Eye Problems			Other _____		
Seizures			Ear/ Nose Trouble			Other _____		

(5) PREVIOUS HOSPITALIZATIONS/OPERATIONS

Date	Reason

I certify that all the above information is complete and accurate to the best of my knowledge.

Signature of Student _____ Date _____

TO BE FILLED OUT BY PHYSICIAN (Pages 3-4)

MANDATORY FOR ENROLLMENT

TETANUS-DIPHTHERIA (REQUIRED)

Month

Day

Year

1. Completed primary series of tetanus-diphtheria immunizations

2. Received tetanus-diphtheria booster within last 10 years

M.M.R. MEASLES, MUMPS, RUBELLA (REQUIRED)

1. Dose 1-immunized on or after 12 months of age

2. Dose 2-immunized after 1987

Provide proof of confirmed disease or immune titer if needed

TUBERCULOSIS (REQUIRED)

1. PPD (mantoux) test within the past year

Results _____

2. Positive PPD. Chest x-ray required

Give date and results of chest x-ray

3. Had BCG vaccine. Chest x-ray required

Give date and results of chest x-ray

VARICELLA - CHICKEN POX (REQUIRED)

(Immunity verified by one of the following:)

1. Personal history of Varicella (list date)

2. Health care provider diagnosed Varicella (list date)

3. Immunity indicated by titer (date of titer)

4. Two injections of Varicella vaccine (list dates)

POLIO (REQUIRED)

1. Adequate primary series of polio (if immunization status cannot be documented, primary series must be started with

written agreement to complete the series according to schedule.)

HEPATITIS B (RECOMMENDED)

1. Adequate series of hepatitis B (specify dates)

or

2. Immunity indicated by titer (specify dates of titer)

MENINGOCOCCAL MENINGITIS (RECOMMENDED)

1. Vaccination No Yes (If yes, provide date)

TO BE FILLED OUT BY PHYSICIAN (Pages 3-4)

MANDATORY FOR ENROLLMENT

Patient's Full Name _____

Birthdate _____ Weight _____ Height _____

Blood Pressure _____ / _____ Pulse _____ Respiration _____

Please Give Details of Any Abnormal Findings

Head _____ Neck _____

Skin _____ Eyes _____

EENT _____

Chest _____ Heart _____

Abdomen _____ Extremities _____

List Any Additional Comments _____

Are you aware of any medical or psychological problems which might affect this student's ability to carry a full load of academic studies? No Yes If yes, please document the nature and the extent of the limitation.

Are you aware of any medical or psychological problems which might affect this student's ability to participate in any physical activities or social events? No Yes If yes, please document the nature and the extent of the limitation.

REQUIRED INFORMATION FOR PRE-NURSING & NURSING MAJORS ONLY

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to grasp securely with at least one hand. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to lift up to 50 pounds. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to carry objects weighing up to 25 pounds. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to walk without assistance of canes, crutches, walkers, animals and/or humans. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual has eye-hand coordination and dexterity to perform nursing procedures and write legibly. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual has normal or corrected refraction within the ranges of 20/20 to 20/190. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to distinguish color shade changes. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual has normal or corrected hearing ability within 0 to 45 decibal range. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to (in at lease one hand) perceive temperature changes and pulsations and to differentiate between various textures and structures. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to communicate verbally and in written form. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is able to adapt to the environment, function in everyday activities, and cope with stressors. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Individual is allergic to latex. |
- I release this individual to participate in nursing clinical activities.
- I release this individual to participate in nursing clinical activities with the following restrictions _____
- I do not release this individual to participate in nursing clinical activities.

By signing below, I acknowledge that the information on pages 3 and 4 of this document is accurate and complete.

Physician's Name _____ Signature _____

Address _____ Phone (_____) _____

City _____ State _____ Zip _____