COMPLETION REQUIRED PRIOR TO REGISTRATION

Kentucky Christian University
ESTABLISHED 1919

For Term Beginning

Fall____________________

Spring__________________

Student Health Information

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 a licensed healthcare provider for the required physical exam and immunizations. **Send the entire completed form to:** Kentucky Christian University, Student Services Office, 100 Academic Parkway, KCU Box 728, Grayson, Kentucky 41143-2205.

Today's Date________/________/__________ (Month / Day / Year)

Gender ❑ Male ❑ Female

Student's Date of Birth________/________/__________ (Month / Day / Year)

Student's Full Name____SSN____________________

Home Address____Home Phone (________)________________

City__________________________State______Zip______________Student Cell (________)________________

Sport(s) of Participation____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

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

Father/Guardian's Name__________________________

Address__________________________________ (If different from your home address)

City______________________________________

State__________Zip__________________________

Employer__________________________________

Employer Phone (________)____________________

Cell Phone (________)________________________

Mother/ Guardian's Name__________________________

Address__________________________________ (If different from your home address)

City______________________________________

State__________Zip__________________________

Employer__________________________________

Employer Phone (________)____________________

Cell 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____

TO BE FILLED OUT BY STUDENT OR PARENT/GUARDIAN

(1) FAMILY HISTORY

Name	Age	Health Status	If Deceased, List Yr./Cause
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			

(2) CURRENT MEDICATIONS (INCLUDES PSYCHOTROPICS)

Drug Name	Dose and Frequency	Reason

(3) ALLERGIES (MEDICATIONS, FOODS, ENVIRONMENTAL)

Allergic To	Reaction	Treatment

(4) MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Anemia or other Blood Diseases			Rupture/Hernia			Bone/Joint Deformity		
Concussion			Rheumatic Fever			Eye Disease		
Hepatitis			Stomach/Intestinal			Mononucleosis		
Meningitis			Cancer			Kidney Problems		

Please explain all YES answers. Attach a separate sheet if necessary. ______

______

(5) MEDICAL ILLNESS OR PROBLEMS

Heart Disease (hypertension, etc.)______

Endocrine problem (thyroid, diabetes, etc.)______

Epilepsy (seizure disorder)______

Pulmonary problem (bronchitis, asthma, pneumonia, etc.)______

Other______

(6) MENTAL HEALTH CARE (Psychiatric or Psychological)

Eating Disorder (anorexia, bulimia)______

Mood Disorder (Depression/Bipolar disorder, etc.)______

AnxietyDisorder______

Suicide attempts______

Alcohol/Drug treatment: Dates of treatment______

Outpatient/Inpatient history: Diagnois, Dates of treatment, ______

(7) 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______

NURSING MAJORS: **In order to complete clinical assignments, nursing majors MUST have all immunizations completed. Hospitals will not approve your clinical placement without them. In addition to the immunizations listed below, annual influenza vaccinations. Annual TB health screening: TB blood test or 2-step TB skin test initially, TB test annually thereafter. If positive results, provide clear chest x-ray (lab report required).**

TO BE FILLED OUT BY LICENSED HEALTH CARE PROVIDER (Pages 3-4)

MANDATORY FOR ENROLLMENT

Student Name (LAST)________________________________**(FIRST)**________________________**(MIDDLE INITIAL)**_____

TETANUS-DIPTHERIA-PERTUSSIS (REQUIRED) Month Day Year

One time dose of Tdap (within past 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 (Date Given) ________________________________

   Results______________________________________ (Date Read) ________________________________

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
   (**NOTE:** Nursing students must have a two-step PPD
   or Lab annually with risk assessment) ________________________________

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) ________________________________

HEPATITIS B (REQUIRED FOR NURSING PROGRAM ONLY)

Dose #1 ________________________________

Dose #2 (1 month post first dose) ________________________________

Dose #3 (5 months post dose #2) ________________________________

MENINGOCOCCAL MENINGITIS (RECOMMENDED)

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

Please Note: *The information you provide on this form is strictly for the use of the Student Services Office, and/or the Yancey School of Nursing and will not be released to anyone without your knowledge and consent.*

TO BE FILLED OUT BY LICENSED HEALTH CARE PROVIDER (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

Yes	No	
❑ Yes	❑ No	Individual is able to grasp securely with at least one hand.
❑ Yes	❑ No	Individual is able to lift up to 50 pounds.
❑ Yes	❑ No	Individual is able to carry objects weighing up to 25 pounds.
❑ Yes	❑ No	Individual is able to walk without assistance of canes, crutches, walkers, animals and/or humans.
❑ Yes	❑ No	Individual has eye-hand coordination and dexterity to perform nursing procedures and write legibly.
❑ Yes	❑ No	Individual has normal or corrected refraction within the ranges of 20/20 to 20/190.
❑ Yes	❑ No	Individual is able to distinguish color shade changes.
❑ Yes	❑ No	Individual has normal or corrected hearing ability within 0 to 45 decibal range.
❑ Yes	❑ No	Individual is able to (in at lease one hand) perceive temperature changes and pulsations and to differentiate between various textures and structures.
❑ Yes	❑ No	Individual is able to communicate verbally and in written form.
❑ Yes	❑ No	Individual is able to adapt to the environment, function in everyday activities, and cope with stressors.
❑ Yes	❑ 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.

Health Care Provider_______________ Signature_______________

Address_______________ Phone (______)_______________

City_______________ State__________ Zip_______________

Date_______________