

SECTIONS I-VII TO BE COMPLETED BY THE STUDENT/PARENT

I. Name _____ M F Date of birth _____ Place _____
Last First Middle City State Country

Home address _____ Phone _____ Height _____ Weight _____
Number and street City State Zip Cell

Parent, guardian or nearest relative _____ Phone _____
Name Relationship Address Cell Home Work

Family physician _____ Phone _____
Name Address

Specialist _____ Phone _____
Name Speciality Address

II. Have you ever had or do you now have any of the following?

Check each item	Yes	Year	Check each item	Yes	Year	Check each item	Yes	Year
1. Allergies (medicines, food, latex)			10. Gastrointestinal problems			19. Psychological counseling		
2. Anemia			11. Hearing loss			20. Recurrent ear problems		
3. Anorexia/bulimia			12. Heart disease			21. Rheumatic/scarlet fever		
4. Asthma			13. Hepatitis			22. Sexually transmitted disease		
5. Attention deficit disorder			14. High blood pressure			23. Thyroid problems		
6. Childbirth			15. Kidney disease/stones			24. Urinary tract infection		
7. Depression or anxiety			16. Meningitis			25. Vision problems (contacts or glasses) or other		
8. Diabetes			17. Mononucleosis			26. Other		
9. Epilepsy/seizures			18. Pneumonia			27. Other		

III. Family history (parent, grandparent, brother, sister) of the following?

Check each item	Yes	No	Relation	Check each item	Yes	No	Relation
Alcoholism				Mental or nervous disorder			
Diabetes				Other			
High blood pressure				Other			
Heart trouble				Other			
TB				Other			

IV. If you answered yes to questions of your health, give details along with corresponding number.

Have you ever had any abnormal **ALLERGIC REACTIONS** to any medications, foods or immunization (penicillin, serum, etc.)?

No Yes If yes, explain _____

List any **MEDICATIONS** you take regularly (dose and schedule):

Have you ever had a serious illness (not listed) or injury?

No Yes If yes, explain _____

Have you ever had surgery or been hospitalized?

No Yes If yes, explain _____

V. HEALTH INSURANCE – IF YOU ARE CURRENTLY COVERED BY A HEALTH INSURANCE PLAN, PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK).

VI. UNDERAGE STUDENTS – Parent permission for treatment is required for Xavier students under age 18. IF YOU ARE UNDER 18 YEARS OF AGE, PARENTS MUST COMPLETE THIS SECTION: I hereby give permission for the Xavier University Health and Counseling Center to render such diagnostic, therapeutic or minor operative procedures as they deem necessary for my son/daughter.

Signed _____ Date ____/____/____

Parent or guardian

Name _____

Date of birth _____

VII. MENINGOCOCCOL AND HEPATITIS B VACCINATION STATUS – As required to comply with Ohio Revised Code, section 3701.133, (B). Must complete if you will be living in a campus residence.

I, The undersigned student (if 18 years of age or older) or parent (if student is under 18), have read and understand the information provided to me about Meningococcal Meningitis and Hepatitis B. I understand the benefits and risks of being vaccinated against these diseases. The information below regarding my/my student's vaccination status is accurate.

Meningococcal vaccine received: Yes No

Hepatitis B vaccine received: Yes No

Signed _____ Date ____/____/____

Student/Parent or guardian (if student is under 18)

THIS SECTION MUST BE COMPLETED BY A PHYSICIAN

VIII. IMMUNIZATION INFORMATION – The Xavier University requirement is proof of two MMR vaccinations, if born after 1956, or immunity evidence (MMR titer). Other vaccinations are optional.

A. MMR (Measles, Mumps, Rubella) Two doses if born after 1956. (REQUIRED)

- 1. Dose 1 given at age 12-15 months or later..... #1 ____/____/____
Mo. Day Yr.
- 2. Dose 2 given at age 4-6 years or later, and at least one month after first dose... #2 ____/____/____
Mo. Day Yr.

B. TETANUS-DIPHTHERIA OR TETANUS-DIPHTHERIA-ACELLULAR-PERTUSSIS (within 10 yrs)

- 1. Tetanus-Diphtheria (Td) ____/____/____
Mo. Day Yr.
- OR**
- 2. Tetanus-Diphtheria-Acellular Pertussis (Tdap) ____/____/____
Mo. Day Yr.

C. HEPATITIS B Three doses of vaccine or a positive Hepatitis surface antibody (Recommended)

- 1. Immunization (Hepatitis B)
 - a. Dose #1 ____/____/____ Yr. b. Dose #2 ____/____/____ Yr. c. Dose #3 ____/____/____ Yr.
- 2. Immunization (Combined Hepatitis A and B Vaccine)
 - a. Dose #1 ____/____/____ Yr. b. Dose #2 ____/____/____ Yr. c. Dose #3 ____/____/____ Yr.
- 3. Hepatitis B surface antibody Date ____/____/____
Mo. Day Yr.
Reactive ____ Non-reactive ____

D. HEPATITIS A

- 1. Immunization (Hepatitis A)
 - a. Dose #1 ____/____/____ Yr. b. Dose #2 ____/____/____ Yr.

E. VARICELLA Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years (recommended).

- 1. History of disease Yes ____ No ____
- 2. Varicella antibody ____/____/____ Reactive ____ Non-reactive ____
Mo. Day Yr.
- 3. Immunization
 - a. Dose #1 #1 ____/____/____
Mo. Day Yr.
 - b. Dose #2, given at least one month after first dose, if age 13 years or older..... #2 ____/____/____
Mo. Day Yr.

F. POLIO (Primary series in childhood.)

Completion of primary series Date ____/____/____
Mo. Day Yr.

G. MENINGOCOCCAL TETRAVALENT – One dose (strongly recommended) for college freshmen living in residence halls. Any undergraduate under age 25 may choose to be vaccinated to reduce their risk of disease.

Tetavalent conjugate (preferred; data for revaccination pending) Date ____/____/____
Mo. Day Yr.

Tetavalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues) Date ____/____/____
Mo. Day Yr.

H. TUBERCULOSIS SKIN TEST (Required for international students who have arrived within the past 5 years from countries where TB is endemic.)

Date given ____/____/____ Date read ____/____/____
Mo. Day Yr. Mo. Day Yr.

Result: ____ (Record actual mm of induration, transverse diameter; if no induration, write "O")

Interpretation (based on mm of induration as well as risk factors): Positive ____ Negative ____

Chest X-ray (required if tuberculin skin test is positive) result: Normal ____ Abnormal ____

Date of chest X-ray ____/____/____
Mo. Day Yr.

I. TYPHOID vaccine (for travel to certain destinations)

Injectable ____/____/____ or Oral ____/____/____
Mo. Day Yr. Mo. Day Yr.

J. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV) Three doses of vaccine for female college students 11-26 years of age at 0, 2 and 6-month intervals.)

Immunization (HPV)

- a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

Health care provider (MUST BE SIGNED BY HEALTH CARE PROVIDER AND STAMPED WITH OFFICE ADDRESS STAMP)

Name _____

Address _____

Phone (____) _____

Signature _____

NOTE: DOCUMENTATION OF UP-TO-DATE IMMUNIZATIONS MUST BE RETURNED BY AUG. 1 TO MAINTAIN YOUR ENROLLMENT.

Mail to: Xavier University, Health and Counseling Center, 3800 Victory Parkway, Cincinnati, Ohio 45207-7611