Please return completed forms to:
Southwest Baptist University
Killian Health Center
803 S. Pike
Bolivar, MO 65613

HEALTH HISTORY and IMMUNIZATION RECORD

NAME _____

HOME ADDRESS _____
Street City State Zip Country

CELL PHONE (_____) _____ DATE OF BIRTH _____
Day Month Year

Male: _____ Female_____

EMERGENCY CONTACT INFORMATION (state relationship) _____

NAME _____

ADDRESS _____
City State Zip Country

(_____) _____ (_____) _____
HOME PHONE WORK PHONE

CONFIDENTIAL MEDICAL HISTORY Do you have a past or present history of the following? *Check all that apply*

___ Alcohol abuse	___ Drug abuse	___ Intestinal/stomach trouble	___ Rubella
___ Anemia	___ Ear trouble	___ Joint disease	___ Scarlet fever
___ Arthritis	___ Eating disorder	___ Measles, Red	___ Skin Problems
___ Asthma	___ Eye disease	___ Menstrual problems	___ Seizures
___ Back problems	___Gallbladder trouble	___ Migraine headaches	___ Sickle Cell Trait/Anemia
___ Cancer	___Hay fever	___ Mononucleosis	___ Sinus trouble
___ Colds	___ Head injury	___ Mumps	___ Smoking
___ Convulsions	___ Headache	___ Pneumonia	___ Stomach Trouble
___ Cough	___ Heart disease	___ Paralysis	___ Spleen, surgical removal
___ Depression	___ Hepatitis/jaundice	___ Polio	___ Thyroid disease
___ Diabetes	___ Hernia rupture	___ Psychological consult	___ Tuberculosis
___ Disability	___ High blood pressure	___ Rheumatic fever	___ Urinary tract infections

___ Other _____

Brief explanation of any marked above _____
_____

Medications_____

Drug allergies _____

Other allergies (animals, seasonal, food, etc.) _____

Hospitalizations and/or surgeries _____

FAMILY HISTORY: Place relationship in blank. *Check all that apply*

o Alcohol/drug abuse _____	o Elevated cholesterol _____
o Bleeding disorder _____	o Heart disease _____
o Cancer/type _____	o Hypertension/stroke _____
o Death before age 50 _____	o Mental illness _____
o Diabetes _____	o Thyroid problem _____

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REQUIRED IMMUNIZATIONS

Department of Physical Therapy

STUDENT NAME: _____ **DATE OF BIRTH**_____

PLEASE PROVIDE DATES FOR ALL OF THE FOLLOWING: **DATE RECEIVED: month/day/year**

I. MMR (Measles, Mumps, Rubella) Two doses required:
#1 _____
#2 _____

II. Meningococcal Meningitis Vaccine:
#1_____
#2_____

III. Tdap (Tetanus/Diphtheria and Pertussis)
#1._____

IV. Polio Series
#1._____
#2._____
#3._____

V. DPT (Diphtheria, Pertussis, Tetanus) series
#1._____
#2._____
#3._____
#4._____

I. Hepatitis B
#1._____
#2._____
#3._____

RECOMMENDED

II. Hepatitis A
#1._____
#2. _____

III. Varicella (chicken pox)
#1._____
#2._____

III. Annual Influenza
#1. _____

IV. HPV (Series of three)
#1. #2. #3.

Physician Verification:

Physician Printed Name **Physician Signature** **Date**

_____ _____ _____

Note: Obtain complete copies of immunization records and attach to this form. Please retain original documentations. Examples of acceptable documentation include:

- Copies of personal immunization records such as baby book immunization records.
- Copies of physician office or Public Health Department immunization records.
- Copies of high school or previous college immunization records.
- Signature and verification of Physician on the above form.

SBU
KILLIAN HEALTH CENTER
Be healthy. Stay well.

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REQUIRED TUBERCULOSIS SCREENING QUESTIONNAIRE

NAME: _____ STUDENT ID#_____DATE:_____

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? ❑ Yes ❑ No
(If yes, please CIRCLE the country, below)

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Have you visited one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above and provide the date you visited the country or countries). ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, Southwest Baptist University requires that you receive TB testing as soon as possible at your own cost. TB skin testing is offered at the SBU Killian Health Center for a cost of $5.00. Call 417-328-1888 to schedule an appointment.

If the answer to all of the above questions is NO, no further testing or further action is required.
Note: ***Missouri Senate Bill No 197 requires all institutions of higher education in Missouri to implement a targeted testing program on their campuses for all students upon matriculation. Any entering student of an institution of higher education in Missouri who does not comply with the targeted testing program shall not be permitted to maintain enrollment.***