

Health History

All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to-know basis only.

Describe any current medical or mental health issues requiring on going care.

Have you ever had any of the following?

	Yes	No
Operation or serious injury	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis (Mono)	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Adverse or allergic reaction to any medication specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction to food, insect bites, or other stimulus not related to medication specify _____	<input type="checkbox"/>	<input type="checkbox"/>

List current medications.

Have you ever had or been treated for any of the following?

Serious disease of eyes, ears, nose, or throat	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches or convulsions, or a severe head injury	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease, asthma, persistent cough, or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem	<input type="checkbox"/>	<input type="checkbox"/>
Sugar, protein, or blood in urine, or bladder or kidney problem	<input type="checkbox"/>	<input type="checkbox"/>
A sexually transmitted disease (STD)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, thyroid, or other endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other disorder of the blood	<input type="checkbox"/>	<input type="checkbox"/>
Bone, joint, or muscle problem; back pain; arthritis; physical deformity; or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever, asthma, hives, or other allergy	<input type="checkbox"/>	<input type="checkbox"/>
Severe acne, eczema, or other skin disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or other tumor	<input type="checkbox"/>	<input type="checkbox"/>
A disorder not listed above (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you...

	Yes	No
Smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Amount: _____ Years: _____		
Drink alcoholic beverages: (number of drinks per week) _____	<input type="checkbox"/>	<input type="checkbox"/>

Have you had or experienced any of the following?

Depression	<input type="checkbox"/>	<input type="checkbox"/>
An anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
An eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>
An anger management issue	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>
A suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>
A sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>
Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>
A learning disability	<input type="checkbox"/>	<input type="checkbox"/>
An antisocial or conduct disorder	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or substance abuse or dependence	<input type="checkbox"/>	<input type="checkbox"/>
An act of self-mutilation (cutting, branding, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Do you intend to begin or continue psychotherapy during college?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized for a psychiatric disorder? (specify dates) _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for alcohol and/or drug addiction? (specify dates) _____	<input type="checkbox"/>	<input type="checkbox"/>

Use the space below to elaborate on any of the above questions.

Continued

Disability Accommodations

All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to-know basis only in accordance with federal guidelines.

List any physical, psychological, or learning disabilities that could affect your health or performance in college along with any medications prescribed for your condition.

Have you provided documentation of your disability to the University of Minnesota, Morris Disabilities Service Office?

Yes No

Health Insurance

Name of insurance company: _____ Group No: _____
 ID Number: _____ Insurance phone number to call in an emergency: _____

Emergency Contact

Name: _____ Relationship to student: _____
 Home telephone: _____ Work telephone: _____ Cell Phone: _____

Signature

I certify that the above information is a true and accurate statement.

Student Signature

Date

If student will be under 18 years old at time of enrollment Parent/Guardian consent is required.

The law requires that a parent/guardian grant permission for medical evaluation and/or treatment of minors (anyone under 18 years of age). The following consent must be signed by a parent/guardian of a minor so that she/he may receive medical evaluation/treatment. No major medical or surgical procedure will be performed, except in an emergency without the parent/guardian first being contacted.

The undersigned parent/guardian hereby grants permission for University of Minnesota, Morris personnel to provide medical evaluation, treatment and/or emergency treatment for the above-named minor. The undersigned parent/guardian further agrees to pay all expenses from of such evaluation and/or treatment.

Name of Parent/Guardian

Telephone

Signature

Date

Continued

Minnesota laws require post-secondary schools to provide students with information on the transmission, treatment, and prevention of hepatitis A, B, C, and meningococcal disease.

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV). Hepatitis B is a highly contagious disease that infects the liver and can lead to cirrhosis, liver cancer, and even death. Hepatitis B is spread through contact with the blood of an infected person or by having sex with an infected person.

Hepatitis A is a liver disease caused by the hepatitis A virus (HAV). Hepatitis A can affect anyone. Hepatitis A is still a common disease in the United States and is spread by close contact with someone who is infected. It is also spread by contaminated food and water. Adults need hepatitis A vaccine for long-term protection.

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV), which is found in the blood of persons who have this disease. The infection is spread by contact with the blood of an infected person. Most persons who get hepatitis C carry the virus for the rest of their lives. There is no vaccine to prevent hepatitis C.

Meningococcal disease is a serious illness, caused by a bacteria. Meningococcal disease is a leading cause of meningitis, an infection of the lining of the brain and the spinal cord. Meningococcal disease also causes blood infections. Anyone can get meningococcal disease. College freshmen who live in dormitories or close living quarters have an increased risk of getting meningococcal disease.

For further information, see Minnesota Department of Health:

Immunization Program

P.O. Box 64975

St. Paul, MN 55164-0975

651-201-5503 or 1-800-657-3970

health.state.mn.us/immunize