Comprehensive Student Health and Disability Report

University of Minnesota, Morris
600 East 4th Street
Morris, MN 56267

Health Services
Office: 320-589-6070
Fax: 320-589-6161
hlthserv@morris.umn.edu

General Information

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. Consult with your health care provider for accurate, complete answers. Social Security number is voluntary and used for identification purposes only. Please print.

Enclose your completed Comprehensive Student Health and Disability Report in the Health Services envelope (included in the front of the New Student Guide). Place the Health Services envelope in the Ready, Set, Go envelope (included in the front of the New Student Guide).

Student Information

Last Name:______________________ First Name:__________________ Middle Name:________________

Home Mailing Address:____

City:____________________________ State:__________ Zip:________ E-mail:_________________________

Home Telephone Number: (____)__________________ Student ID #:________________________________

Date of Birth:___/___/___ Age:____ Gender: ___________ Social Security Number:__________________

Immunization Record

Please complete the following record of immunization as it applies to you.

Required

MMR (Measles, Mumps, Rubella)
Two doses needed - both after 12 months of age and at last four months apart

☐ Date: ____/____/____
☐ Date: ____/____/____
☐ Check here if you were born before 1957 (for the age exemption for the MMR).

Tetanus-Diphtheria Must be within last ten years
☐ Date: ____/____/____

Recommended

Meningitis Vaccine 1 dose needed
☐ Date: ____/____/____

Hepatitis B 3 doses needed
☐ Date: ____/____/____
☐ Date: ____/____/____
☐ Date: ____/____/____

Medical Exemption: The student named above does not have one or more of the required immunizations because he/she has (Check all that apply and fill in the appropriate blanks):

☐ A medical problem that precludes the ____vaccine(s)
☐ Not been immunized because of a history of ____disease
☐ Shown laboratory evidence of immunity against_______________________________________

Physician's Signature:____ **Date:**_____________________

Conscientious Exemption: I hereby certify by notarization that immunization against ________________ is contrary to my conscientiously held beliefs.

Student Signature:____ **Date:**_____________________

Subscribed and sworn before me on the _____________day of _________________ 20________

Signature of Notary:___________________________________ (Required for conscientious exemption)

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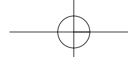

Health History

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 ongoing care.

____

____

____

Have you ever had any of the following?	Yes	No
Operation or serious injury	☐	☐
Hospitalization	☐	☐
Mononucleosis (Mono)	☐	☐
Chicken pox	☐	☐
Tuberculosis	☐	☐
Adverse or allergic reaction to any medication specify ____________________ ____________________	☐	☐
Allergic reaction to food, insect bites, or other stimulus not related to medication specify ____________________ ____________________	☐	☐

List current medications.

____

____

____

Have you ever had or been treated for any of the following?	Yes	No
Serious disease of eyes, ears, nose, or throat	☐	☐
Frequent or severe headaches or convulsions, or a severe head injury	☐	☐
Lung disease, asthma, persistent cough, or shortness of breath	☐	☐
High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels	☐	☐
Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem	☐	☐
Sugar, protein, or blood in urine, or bladder or kidney problem	☐	☐
A sexually transmitted disease (STD)	☐	☐
Diabetes, thyroid, or other endocrine disorder	☐	☐
Anemia or other disorder of the blood	☐	☐
Bone, joint, or muscle problem; back pain; arthritis; physical deformity; or paralysis	☐	☐
Hay fever, asthma, hives, or other allergy	☐	☐
Severe acne, eczema, or other skin disorder	☐	☐
Cancer or other tumor	☐	☐
A disorder not listed above (specify) __________	☐	☐

Do you...	Yes	No
Smoke or chew tobacco? Amount: ____________ Years: _____	☐	☐
Drink alcoholic beverages: (number of drinks per week) ________	☐	☐

Have you had or experienced any of the following?	Yes	No
Depression	☐	☐
An anxiety disorder	☐	☐
An eating disorder	☐	☐
Bipolar disorder	☐	☐
Obsessive-compulsive disorder	☐	☐
An anger management issue	☐	☐
PTSD	☐	☐
ADD/ADHD	☐	☐
Suicidal ideation	☐	☐
A suicide attempt	☐	☐
A sleep disorder	☐	☐
Panic disorder	☐	☐
A learning disability	☐	☐
An antisocial or conduct disorder	☐	☐
Alcohol or substance abuse or dependence	☐	☐
An act of self-mutilation (cutting, branding, etc.)	☐	☐
Do you intend to begin or continue psychotherapy during college?	☐	☐
Have you been hospitalized for a psychiatric disorder?	☐	☐
Have you been treated for alcohol and/or drug addiction? (specify dates) ________________	☐	☐

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

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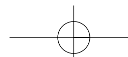

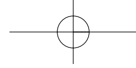

Disability Accommodations

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 UMM's Disabilities Services Office?
__ Yes __ No

Health Insurance

Name of insurance company:____________________ Group No:____________
Cert. No:__________ 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

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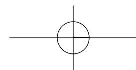

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Information on Meningitis and Hepatitis

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.0. Box 64975
St. Paul, MN 55164-0975
651-201-5503 or 1-800-657-3970
www.health.state.mn.us/immunize