



ROCKHURST UNIVERSITY STUDENT DEVELOPMENT  
HEALTH HISTORY AND IMMUNIZATION RECORD

Please submit this form by August 1 to Rockhurst University (Massman 1)

Student Information

Full Name \_\_\_\_\_ RU ID \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First semester enrolled at Rockhurst: \_\_\_\_\_ Anticipated Graduation Date: \_\_\_\_\_

Emergency Contact Information

Contact Full Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Family Physician Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Primary insured Name \_\_\_\_\_ Relationship to student \_\_\_\_\_  
Name/Address of Insurance Company \_\_\_\_\_  
Policy No./Group No. \_\_\_\_\_ Policy Holder SSN # \_\_\_\_\_

Health History

Please list any current /chronic health problems: \_\_\_\_\_

Please list any medications you are now taking: \_\_\_\_\_

Please list the Dates and types of Surgeries you may have had: \_\_\_\_\_

Please list the Date(or age) and type of SERIOUS illness or injury you may have had: \_\_\_\_\_

Are you allergic to any drugs?  Yes  No  
\_\_\_\_\_ if yes please specify

Do you have any environmental/seasonal allergies?  Yes  No  
\_\_\_\_\_ if yes please specify

Will you be needing on-going healthcare for a chronic medical condition while at Rockhurst?  Yes  No  
\_\_\_\_\_ If yes please specify

**Turn over to complete the immunization record.**

**Required Immunizations:** To be completed by a health care provider or attach documentation from a clinic/provider

A) **Measles, Mumps, & Rubella (MMR)** Documentation of two measles, mumps, and rubella vaccinations is **required** for all students. Please document below and include a copy of your current immunization record.

Requirements:	<u>Born in 1957 or later:</u>	<u>Born in 1956 or before:</u>
	Measles (Rubeola) 2 doses of the vaccine	Measles (Rubeola) Date of disease or lab report of the titer
	Mumps 2 doses of the vaccine	Mumps Lab report of titer or physician's documentation of diagnosed disease is required.
	Rubella 2 doses of the vaccine	Rubella Lab report of titer or physician's documentation of diagnosed disease is required.

MMR          /    /              /    /      
                     Date of 1<sup>st</sup> injection      Date of 2<sup>nd</sup> injection

\*If you have had MMR vaccinations, you do not need to fill in information for Measles, Mumps or Rubella separately in section B.

B) Measles (Rubeola)          /    /              /    /          OR       Titer report Attached  
   Date of 1<sup>st</sup> dose      Date of 2<sup>nd</sup> dose

Rubella          /    /              /    /          OR       Titer report Attached  
   Date of 1<sup>st</sup> dose      Date of 2<sup>nd</sup> dose

Mumps          /    /              /    /          OR       Titer report Attached  
   Date of 1<sup>st</sup> dose      Date of 2<sup>nd</sup> dose

C) Meningitis Vaccination OR education/waiver per Missouri state law (See enclosed meningitis information.)

    /    /          (      )      \_\_\_\_\_  
                     Date of immunization      Phone number of provider      Signature of provider

**Additional Recommended Immunizations**

D) Hepatitis A          /    /              /    /      
   Date of 1<sup>st</sup> dose      Date of 2<sup>nd</sup> dose

E) Hepatitis B          /    /              /    /              /    /      
   Date of 1<sup>st</sup> dose      Date of 2<sup>nd</sup> dose      Date of 3<sup>rd</sup> dose

F) Varicella (Chicken Pox)          /    /              /    /      
   Date of illness      Date of immunization

G)  Tetanus / Diphtheria (Td)          /    /      
 Tetanus/Diphtheria/Pertussis (Tdap)      Date of last booster

\*After initial series a tetanus booster should be given every 10 years. Tdap is now the recommended booster.

H) TB Screening          /    /          \_\_\_\_\_  
     (Tuberculosis)      Date Last TB test      Result (\*Positive / Negative)

\*If TB result positive provide documentation of follow up / treatment by a physician / practitioner.

**Please list any other vaccinations you may have had:**

Type: \_\_\_\_\_ Date: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Rockhurst University to release this immunizations record to public health authorities for compliance audits and/or in the event of a health or safety emergency, and to health care providers and institutions to which I may be assigned during my educational experience if I choose a health profession related major.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_