



Return this form to:  
Rockhurst University  
Office of Student Development  
Kansas City, MO 64110  
FAX: 816-501-4845  
Due by: August 14, 2009

## Rockhurst University Health History and Immunization Record

### Student Information

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

### Physician Emergency Contact Information

Family Physician Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Health History

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

Please list any medications (other than contraceptives) you are now taking: \_\_\_\_\_

Please list the dates and types of surgeries you have had: \_\_\_\_\_

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

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

Other health comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 separate Measles, Mumps or Rubella 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)          /    /          **OR**          /    /      
 Date of illness      Date of immunization

G)  Tetanus / Diphtheria (Td) "Booster"          /    /      
 Tetanus/Diphtheria/Pertussis (Tdap) "Booster"      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 immunization 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: \_\_\_\_\_