University of Minnesota
CROOKSTON

Medical History

To the Student:
Information you provide will be used to provide necessary health care while you are a student.

Submit completed form to Student Health Services, 145 F Sargeant Student Center,2900 University Ave, Crookston, MN 56716 or Fax to 218-281-8588. For questions, contact Health Services at 218-281-8512.

Name _____ Student ID No. _____
(PRINT) (Last) (First) (Middle) (Maiden or Former Name)

Gender M ( ) F ( ) Other _____ Phone_____ Date of Birth _____/_____/_____

Home Address _____
(Number and Street) (City) (State) (Zip Code)

Person to Notify in Case of Emergency

Name _____ Relationship _____

Home Address _____ Home Telephone _____

Business Address _____ Business Telephone _____

Health Insurance Name _____ Policy Number _____ Policy Holder _____

Enrollment Year and Semester_____

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below.

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Diabetes			Insomnia			Pain/Pressure in Chest			Skin Disorder		
Chicken pox			Frequent Anxiety			Chronic Coughing			Gallbladder Trouble		
Scarlet Fever			Frequent Depression			Palpitations (Heart)			Recurrent Diarrhea		
Measles			Worry or Nervousness			High or Low Blood Pressure			Dizziness, Fainting		
German Measles			Recurrent Headaches			Rheumatic Fever			Weakness, Paralysis		
Mumps			Recurrent Colds			Heart Murmur			Sexually Transmitted Disease		
Epilepsy			Hay Fever, Asthma			Disease or Injury of Joints			Frequent Urination		
Sinusitis			Tuberculosis			Back Problems					
Ear, Nose, Throat Trouble			**Allergy**			Tumor, Cancer, or Cyst			FEMALES ONLY		
Eye Trouble			Penicillin			Jaundice			Irregular Periods		
Surgery			Sulfonamides (Sulfa)			Stomach/Intestinal Trouble			Severe Cramps		
Head Injury with Unconsciousness			Foods (which)			Eating Disorder			Excessive Flow		
			Other								

A. Has your physical activity been restricted during the past three years? (Give reasons and durations.)

B. Have you received treatment or counseling for an emotional problem? (Give details.)

C. Have you had any illness or been hospitalized other than already noted? (Give details.)

D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past three years? (Other than routine checkups?)

Comments:

MEDICATION: List of Medication **YOU** Are Currently Taking

I hereby state that the above information is true and give permission for the Student Health Service to release information to health care providers and facilities who are included in my medical treatment.

_____
Student's Signature Date

_____
Parent Signature (if student is under 18) Date

DISABILITY SERVICES ● Optional Section, *but strongly encouraged*

Information in this section will be shared with UMC's Office for Students with Disabilities. Students who complete this section will receive an additional mailing from the Office for Students with Disabilities.

Do you have a medical or educational related disability that may have an impact on your academic program? If yes, please specify.

PARENTAL CONSENT

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 he/she 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.

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

Name of parent/guardian _____
Phone_____

Signature of parent/guardian _____
Date_____

▼ OVER

OFFICE USE ONLY: PeopleSoft☐ Date

Immunization Record for Students Attending Post-Secondary Schools in Minnesota

Students: **Return this completed form to the post-secondary school you will be attending before enrolling.**

Student Name (Last, First, M.I.)	Date of Birth	Student ID Number	Date of Enrollment (Mo/Yr)

Minnesota Law (M.S. 135A.14) requires proof that all students born after 1956 are vaccinated against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions (see below). Any non-exempt student who fails to submit the required information within 45 days after first enrollment cannot remain enrolled. This form is designed to provide the school with the information required by the law and will be available for review by the Minnesota Department of Health and the local health agency.

☐ Check here if you were born before 1957 for the age exemption. If you were, you don't have to complete the rest of this form; however you still must return this form to your school.

All other students who are not age-exempt: Complete parts 1, 2, 3, and/or 4 below.

Part 1: *Students graduating from a Minnesota high school in 1997 or later*

I have previously met the MMR (measles, mumps, rubella) and Td (tetanus, diphtheria) requirements because I graduated from a Minnesota high school in 1997 or later.

Student's signature _____ Date _____

Name of high school:	City:	Date of graduation:

Part 2: *Transfer student from another Minnesota college*

I am exempt from these requirements because my admission records indicate I have met the requirements as an enrolled student in another post-secondary school in Minnesota. Student's signature_____ Date _____

Name of previous Minnesota college:	Dates of enrollment: from _____ to _____

Part 3: *Students who graduated from a Minnesota high school before 1997 or students from out of state*	Mo/Day/Yr	Mo/Day/Yr
Tetanus/diphtheria (Td or Tdap) 1 dose *(at least one dose required within past 10 years)*		
Measles/mumps/rubella (MMR) 2 doses *(at least one dose required at or after 12 months of age)*		

I certify that the above information is a true and accurate statement of the dates on which I was vaccinated.

Student's signature _____ Date _____

Part 4: *Other exemption(s): A physician's signature is required for a medical exemption, and a notary's signature is required for a conscientious exemption*

Medical Exemption: The student named above lacks one or more of the required immunizations because he/she: *(Check all that apply and fill in the appropriate blanks.)*

☐ has a medical problem that precludes the _____ vaccine
☐ has not been immunized because of a history of _____ disease
☐ has laboratory evidence of immunity against _____ disease

Physician's signature _____ Date _____

Conscientious Exemption: I hereby certify by notarization that immunization against

_____ disease is contrary to my conscientiously held beliefs.

Student's signature _____ Date _____

Subscribed and sworn to before me this ____ day of _____, 20____.

Signature of notary _____

MINNESOTA MDH DEPARTMENT OF HEALTH
Immunization Program
651-201-5503 or 1-800-657-3970
www.health.state.mn.us/immunize