

STUDENT HEALTH FORM

Mount Angel Seminary
1 Abbey Drive, St. Benedict, OR 97373
503-845-3951

PLEASE PRINT

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY	STATE ZIP
PHONE	PLACE OF BIRTH	COUNTRY OF CITIZENSHIP
DATE OF BIRTH	SOCIAL SECURITY ID#	
ENTERING SEMESTER DATE		

NOTIFY IN CASE OF EMERGENCY

NAME	NAME
RELATIONSHIP	RELATIONSHIP
HOME PHONE WORK PHONE	HOME PHONE WORK PHONE
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE CO. NAME	ID#	PLAN	GROUP
SUBSCRIBER'S NAME			
SECONDARY INSURANCE CO. NAME	ID#	PLAN	GROUP
SUBSCRIBER'S NAME			

ALLERGIES

(Please note type of reaction)

FOOD (LIST FOOD)	LIFE THREATENING?	YES	NO
DRUG (LIST DRUG)	LIFE THREATENING?	YES	NO
INSECT (LIST INSECT)	LIFE THREATENING?	YES	NO
OTHER (LIST)	LIFE THREATENING?	YES	NO

PERSONAL MEDICAL HISTORY

PREVIOUS SURGERY/HOSPITALIZATION/INJURY? EXPLAIN	DATE
PHYSICAL IMPAIRMENT? EXPLAIN	DATE
EMOTIONAL PROBLEMS REQUIRING TREATMENT? EXPLAIN	DATE
CURRENT MEDICATIONS? LIST	DATE

PLEASE MARK ITEM(S) FOR EACH CONDITION YOU HAVE HAD

- | | | |
|---|---|--|
| <input type="checkbox"/> ANXIEY/DEPRESSION | <input type="checkbox"/> EATING DISORDER | <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> GERMAN MEASLES | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> THYROID DISORDER | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> SICKLE CELL ANEMIA | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE | <input type="checkbox"/> DENTAL PROBLEMS |

FAMILY HISTORY
PLEASE MARK ITEM(S) FOR EACH CONDITION A FAMILY MEMBER HAS HAD

ALLERGY	WHO?
ASTHMA	WHO?
CANCER	WHO?
DIABETES	WHO?
HEART DISEASE	WHO?
HIGH BLOOD PRESSURE	WHO?
MENTAL ILLNESS	WHO?
TB	WHO?
OTHER (DESCRIBE)	WHO?

VACCINATION HISTORY

Diphtheria, Pertussis, Tetanus Series (DPT, Dtap)	Dates	Hepatitis A Dates	Hepatitis B Dates
Tetanus Booster (Dt or TD)	Date		
Polio Series	Dates		
Meningococcal Vaccine	Date	Chickenpox Vaccine (Varivax)	Dates

REQUIRED IMMUNIZATIONS AND TB SCREENING

Oregon State Law requires that each entering full-time student born on or after January 1, 1957, must have two doses of Measles vaccine or MMR vaccine (documented by month and year of each dose) on or after the first birthday, with a minimum of 30 days between doses.

CHECK THE TYPE OF VACCINE GIVEN	DATE GIVEN	
MEASLES #1 [] OR MMR []		MUST BE ON OR AFTER 1 ST BIRTHDAY AND 1/1/57
MEASLES #2 [] OR MMR []		MUST BE AT LEAST 30 DAYS AFTER 1ST IMMUNIZATION
RUBELLA		IF GIVEN INSTEAD OF MMR. MUST BE ON OR AFTER 1 ST BIRTHDAY AND 1/1/57

In addition, Mount Angel Seminary requires ALL incoming students regardless of age to provide evidence of TB testing. A MANTOUX/PPD test is required (Tine test is not acceptable). If there has been a positive TB skin test in the past, a repeat test is not necessary but proof of a chest x-ray OR proof of completion of a course of TB medication must be submitted.

MANTOUX/PPD DATE PLANTED	DATE READ	[] NEGATIVE [] POSITIVE _____ mm induration (horizontal diameter)
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PRE-ADMISSION DRUG SCREENING & BLOOD TESTS FOR MOUNT ANGEL SEMINARY

Type of Test: 5 Panel * Positive _____ Negative _____

*Amphetamines/Methamphetamine, Cocaine, Marijuana (THC), Opiates, Barbiturates, Benzodiazepines, Propoxyphene

A full blood screening for HIV, Hepatitis, illegal drug use, sexually transmitted diseases or other occult health issues is required.

I certify that this student has received the drug screening, immunizations or has laboratory evidence of immunity as indicated above, as well as evidence of TB testing or completion of TB medication.

HEALTHCARE PROVIDER SIGNATURE

DATE