IHCC Student Health and Wellness
603 Indian Hills Drive, Trustee Hall
Ottumwa, Iowa 52501-1468

RECOMMENDED (BUT NOT REQUIRED) IMMUNIZATIONS

Name: ______________________________ Date of Birth: _________ _________ __________
Month Day Year

Address: ______________________________ Phone: ____________________________

MMR: All persons born after 1/1/57 must have received 2 injections of MMR vaccine at least one month apart and after their first birthday OR have sufficient rubeola, mumps, and rubella titer OR Physician documentation of acquired disease.

Date of first MMR injection:
________/________/________
Month Day Year

Date of second MMR injection:
_______/________/________
Month Day Year

Tetanus/Diphtheria:
_______ /________ /________
Month Day Year

OR

Tdap (Tetanus/Diphtheria/Pertussis)
_______/________/________
Month Day Year

Hepatitis A #1
_______/__________/________
Month Day Year

Hepatitis A #2
_________/_________/________
Month Day Year

Hepatitis B #1
______/_______/_______
Month Day Year

Hepatitis B #2
_______/_______/_______
Month Day Year

Hepatitis B #3
_______/_______/_______
Month Day Year

Have you had Chicken Pox? _____ Yes _____ No

Varicella (Chicken Pox): Vaccination #1 _____/_____/_____ Vaccination #2 _____/_____/_____

Meningococcal (Meningitis) ________/________/_________
Month Day Year

Other Vaccinations (Typhoid, Yellow Fever, etc.)
Type: ______________________________ _______/_______/_______
Month Day Year

Other Vaccinations (Typhoid, Yellow Fever, etc.)
Type: ______________________________ _______/_______/_______
Month Day Year

IHCC INTERNATIONAL STUDENT HEALTH FORM

Health Report: To be completed by **student -** Please print or type all information

Name: ____
Last First Middle

Date of Birth: ________ _________ __________
Month **Day** **Year**

Address: ____
Street City/Province Country Zip/Postal Code

Personal email address: ____

Parent or Guardian: ____
Last First Relationship

Home Phone: ______________________ Work Phone: ______________________

Address: ____
Street City/Province Country Zip/Postal Code

Medical Insurance Provider: ____
****Please bring a copy of your insurance card****

Address: ____
Street City/Province Country Zip/Postal Code

Person to notify in case of an emergency: ______________________ Relationship: ____________

Address: ____ Phone: ________________

Family History (List all familial diseases: e.g. Diabetic, Asthma, depression, other: ______________________

____

____

Personal History – Have you had or are you now under treatment for any of the following problems?
Please check for YES

___ Allergies/Hayfever
___ Alcohol/Substance Abuse
___ Asthma
___ Back problems
___ Blood disorder
___ Chicken Pox
___ Chronic Bronchitis
___ Chronic intestinal problems

____ Chronic skin problems
____ Diabetes
____ Food allergies
____ Joint disease
____ Kidney disease
____ Malaria
____ Malignancy/Cancer
____ Menstrual problems

_____ Mononucleosis
_____ Pneumonia
_____ Psychiatric problems
_____ Recurrent headaches/Migraines
_____ Sexually transmitted diseases
_____ Seizures (Epilepsy)
_____ Splenectomy
_____ Tuberculosis or TB contact

Please provide a brief explanation of any conditions which were checked on opposite page:

____

____

____

____

*Past surgeries: ____

____

PATIENT CONSENT: I hereby certify that the statements made herein are true and correct to the best of my knowledge. I give my consent to receive services offered to me by Student Health and Wellness. This form is signed with the understanding that pertinent information may be shared to/from physician, hospital, Dept. of Human Services, Dept. of Public Health, IHCC International Affairs office, and any other community agencies. I understand that any information released or obtained will be used as appropriate and necessary for my treatment and does not constitute breach of my rights to confidentiality.

STUDENT SIGNATURE ____ **Date**: _ _ / _ _ / _ _ _ _

****Please fax this information to Student Health and Wellness at (641) 683-5742 when completed****