# MILLSAPS COLLEGE

## WESSON HEALTH CENTER

## Health History Form

**Name** _____
(Last) (First) (Middle)

**Social Security #** _____

**Freshman year** _____ **Junior year** _____

**Sophomore year** _____ **Senior year** _____

**Trad.** _____ **Grad.** _____ **Spec.** _____

**TO THE APPLICANT AND THE PHYSICIAN:**

**The Health History From is *required* for all entering students to complete registration. Please fill out the Health History Form. In order to render more efficient medical care to Millsaps students, the Wesson Health Center staff must have an accurate and comprehensive record of each student's present and past medical experience. Any condition which might affect the student's academic progress or require special attention should be reported. Effort will be made to facilitate continuation of a plan of treatment for the welfare of the student if specific instructions are furnished by the personal physician.**

**The Mississippi State Board of Health in conjunction with the Board of Trustees of the Institutions of Higher Learning require that all new and transfer students must show proof of documented history of two doses of MMR (measles, mumps, rubella) vaccine. It is VERY IMPORTANT that you complete your immunization information. Please note that documentation must be from a healthcare provider (family physician, health department, etc.)**

**This form is used as a permanent record during the student's entire time at Millsaps and is strictly confidential. If you have any questions please call the Office of Student Affairs at 974-1206.**

**THIS FORM MUST BE COMPLETED AND RETURNED BY AUGUST 1 TO: The Wesson Health Center, Millsaps College, 1701 N. State St Box 151062; Jackson, MS 39210. Do not turn it in to other campus offices.**

### MEDICAL HISTORY
### (To be completed by applicant)

**Student's Name** _____ **Age**_____ **Sex**_____
(Last) (First) (Middle)

**Date of Birth** _____ **Marital Status** _____

**Parents' or Spouse's Name** _____

**Home Address** _____ **Telephone**_____

**City** _____ **State**_____ **Zip**_____

**Parents' Business Address (Mother)** _____ **Telephone** _____

**Parents' Business Address (Father)** _____ **Telephone**_____

**PAST MEDICAL HISTORY (Circle those which you have had and note date)**

**Measles (Red) _____German Measles _____ Mumps _____ Chicken Pox _____**

**Hay Fever _____Asthma _____Rheumatic Fever_____Diabetes_____**

**Hepatitis (A,B,C or other)_____Epilepsy_____ Tuberculosis _____**

**Recurrent Tonsillitis_____Blood Disorder/Anemia _____**

**Digestive Disorder_____Bone/joint Problems_____ Psychological Condition_____**

**Other (specify)_____**

**REMARKS concerning the above _____**

**_____**

**_____**

**OPERATIONS/SERIOUS INJURIES – give dates_____**

**_____**

**Do you wear glasses or contact lenses? (check) ____ No ____ All the time ____ Reading only ____ Outside only**

**Do you take any medicine or drugs? _____If so, what and why?_____**

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**Do you use tobacco products? (check) _____Yes _____No**

**Are you allergic to any medicine or drug? _____ If so, give details. _____**

**_____**

**Are you now covered by hospitalization insurance? _____ If so, what company? Give the subscribers name.**

**_____Insurance Number _____**

**Do you know of any reason why you will not be able to participate in all college activities, including athletics?**

**_____ If so, give reason. _____**

**_____**

## *EMERGENCY CONSENT FOR MINORS – Signatures Required*

***Students under 18 years of age cannot give legal consent to be treated in case a medical or psychological emergency arises. In such cases, are you willing to give permission for emergency treatment to be administered?* _____ Yes _____ No**

**Signature of parent or guardian _____Date _____**

**Signature of student _____Date _____**

Updated 3/2013

# Certificate of Immunization Compliance

Millsaps ***requires*** documentation of PPD (TB Skin Test) within the past year and 2 MMR's – 1st after 12 months of age, 2nd at 5 years old or later. **A Meningitis vaccine and a Tetanus booster are strongly recommended.** The Wesson Health Center staff **will** follow up on this to ensure documentation is provided.

Name of Student _____ Birthdate _____

Social Security Number _____

Address _____
Street City State Zip

| | **Date Each Dose Was Given** | | | | |
|---|---|---|---|---|---|
| **Vaccine** | **1st** | **2nd** | **3rd** | **4th** | **5th** |
| DTP/DTaP/DT/Td | | | | | |
| Polio (OPV or IPV) | | | | | |
| Hep B | | | | | |
| MMR | | | | | |
| Varicella | | | | | |
| Other | | | | | |
| Other | | | | | |

**TB Skin Test:** Date Given _____ Date of Results _____ ☐ Positive ☐ Negative

If Positive, CXR Date _____ Results _____

Treatment _____

Health Dept. or Clinic Signature _____

Date Form Completed _____

Updated 3/2013

# PHYSICAL EXAMINATION AND HEALTH CERTIFICATE

**(This page to be completed by the personal physician on the basis of an examination made within 6 months prior to date of admission)**

**(In the following, check approximately as normal or abnormal with explanation)**

| | Normal | Abnormal | Explanation of abnormality |
|---|---|---|---|
| **Eyes** | | | |
| **Ears** | | | |
| **Nose** | | | |
| **Throat** | | | |
| **Neck** | | | |
| **Chest** | | | |
| **Lungs** | | | |
| **Heart** | | | |
| **Abdomen** | | | |
| **Hernia** | | | |
| **Extremities** | | | |
| **Back** | | | |
| **Teeth** | | | |

**Height:**_____ **Weight:**_____ **BP**_____

**Blood Work: LDL**_____ **HDL**_____ **Glucose**_____

**Hematocrit**_____ **% Hemoglobin:** _____

**Urinalysis: SpGR**_____ **Albumin**_____ **Sugar**_____ **Micro**_____

**Known Allergies**_____

**Is there any history or evidence of emotional instability?** _____ **If so, please elaborate.**_____

**If applicable, please record abnormal menstrual history and treatment advised.** _____

**Prescription medications? (Please list)**_____

**Do you consider this student physically and emotionally fit to undertake a college career?** _____

**If the applicant is unfit in any way, what restrictions or corrections would you advise?** _____

**Is student able to participate in athletics?** _____

**If student deemed unable, why?**_____

**REMARKS:** _____

**Examination Date:** _____ **Signed**_____**, M.D.**

_____

**Please Print Name**

**ADDRESS: Street** _____

**City**_____ **State** _____ **Zip** _____