

2. Student Current Medications (Includes Psychotropic, OTC, Vitamins, Supplements)

Drug Name	Dose & Frequency	Reason

3. Student Allergies (Medications, Foods, Environmental)

Allergic To	Reaction	Treatment

4. Student Medical History

	Yes	No		Yes	No		Yes	No
Anemia/Blood Disease			Rupture/Hernia			Bone/Joint Deformity		
Concussion			Rheumatic Fever			Eye Disease		
Hepatitis			Stomach/Intestinal			Mononucleosis		
Meningitis			Cancer			Kidney Problems		

Please explain any YES answer: _____

5. Student Illness or Problems

Heart Disease (hypertension, etc.) _____
 Endocrine problem (thyroid, diabetes, etc.) _____
 Epilepsy (seizure disorder) _____
 Pulmonary problem (bronchitis, asthma, pneumonia, etc.) _____
 Other _____

6. Student Mental Health Care

Eating Disorder (anorexia, bulimia) _____
 Mood Disorder (depression/bipolar disorder, etc.) _____
 Anxiety Disorder _____
 Suicide Attempt (dates) _____
 Alcohol/Drug Treatments (dates) _____
 Outpatient/Inpatient History (diagnosis, dates): _____

7. Student Previous Hospitalizations/Operations

Date	Reason

I certify that all the information provided is complete and accurate to the best of my knowledge.

Student Signature: _____ Date: _____

REQUIRED INFORMATION ON VACCINATION ABOUT MENINGITIS

Pursuant to Kentucky Legislature House bill #342 effective July 1, 2004, KCU Campus Housing is required to provide vaccination information about meningitis to full-time students living in resident housing. Meningococcal meningitis is a rare, but potentially fatal, bacterial infection. The disease is expressed as meningococcal meningitis, the presence of bacteria in the blood. The meningitis vaccine is not available on campus, but is available at the Carter County Health Department. To make an appointment, students should call 606.474.5109. There is a \$26 fee. Please visit www.cdc.gov for more information. Please check the appropriate statement below. The information provided will be kept confidential.

_____ Yes, I have had the meningitis vaccination. If yes, provide the date: _____

_____ No, I have not had the meningitis vaccination.

IMMUNIZATIONS

The following immunizations are required for KCU enrollment.

Everything in this box needs to be filled out by a health care provider OR a copy of your immunization record must be attached to this form listing all required immunizations.

Meningococcal Meningitis (RECOMMENDED)	Month	Day	Year
Vaccination: Yes _____ No _____			
Tetanus-Diphtheria-Pertussis	Month	Day	Year
One time dose of Tdap (within past 10 years)			
M.M.R. Measles, Mumps, Rubella	Month	Day	Year
Dose 1- immunized on or after 12 months of age			
Dose 2- immunized after 1987 – provide proof of confirmed disease or immune titer if needed			
Tuberculosis	Month	Day	Year
PPD (mantoux) test within past year	Given:		
Results: _____ *If positive, see below chart	Read:		

*If positive PPD. Chest x-ray required. Give date and results of chest x-ray: _____

**Had BCG vaccine. Chest x-ray required. Give date and results of chest x-ray: _____

By signing below, I acknowledge that the information above is accurate and complete.

Family Physician: _____ Phone: (_____) _____

Address: _____

Health Care Provider Signature: _____ Date: ____/____/____